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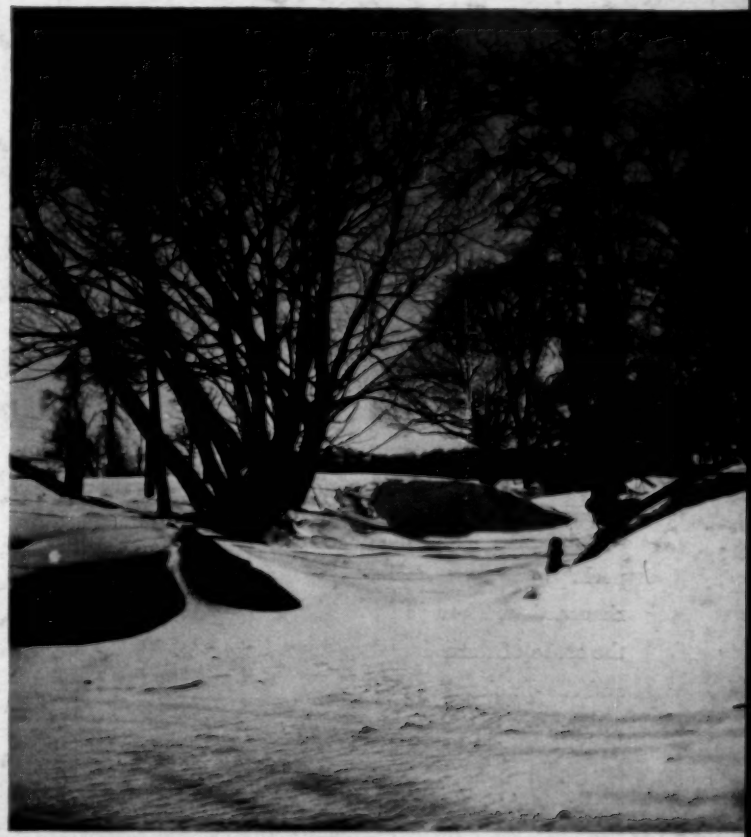
1948

CONGENITAL DISLOCATION OF THE HIP
Dr. W. G. Turner

THE CONSTANT FLAME
Eardley Benedict



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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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Between Ourselves

National Health Week was celebrated this year February 1-7. In the years since this national feature was first organized, general public interest in the active promotion of health has increased. Local health departments all over the land have used this period to publicize their activities. **Lois C. Kelly** describes the effort made in a northern Ontario community and analyzes the effectiveness of these practices. Other localities which have not featured special health weeks heretofore might begin their planning now to make next year's week a special occasion.

Many nurses regard Florence Nightingale as a legendary figure who performed marvels at Scutari and revolutionized training schools for nurses. Few of them have taken the trouble to seek out Florence Nightingale as a vital personality, with a quick, incisive pen, who stormed to good effect against the abuses of her day. The masterly address on this famous lady's writings delivered at the I.C.N. Congress in May, 1947, has been made available through the Florence Nightingale International Foundation. Copies of the oration may be ordered through the Canadian Nurses' Association, 1411 Crescent St., Montreal 25. They sell at **fifty cents** each, the proceeds to be devoted to the activities of the Canadian Florence Nightingale Memorial Committee.

In this issue, we are featuring a commentary on Miss Nightingale's "Notes on Nursing." **Eardley Benedict** is the penname of a well-known Canadian who revitalizes the founder of modern nursing through this analysis of her book.

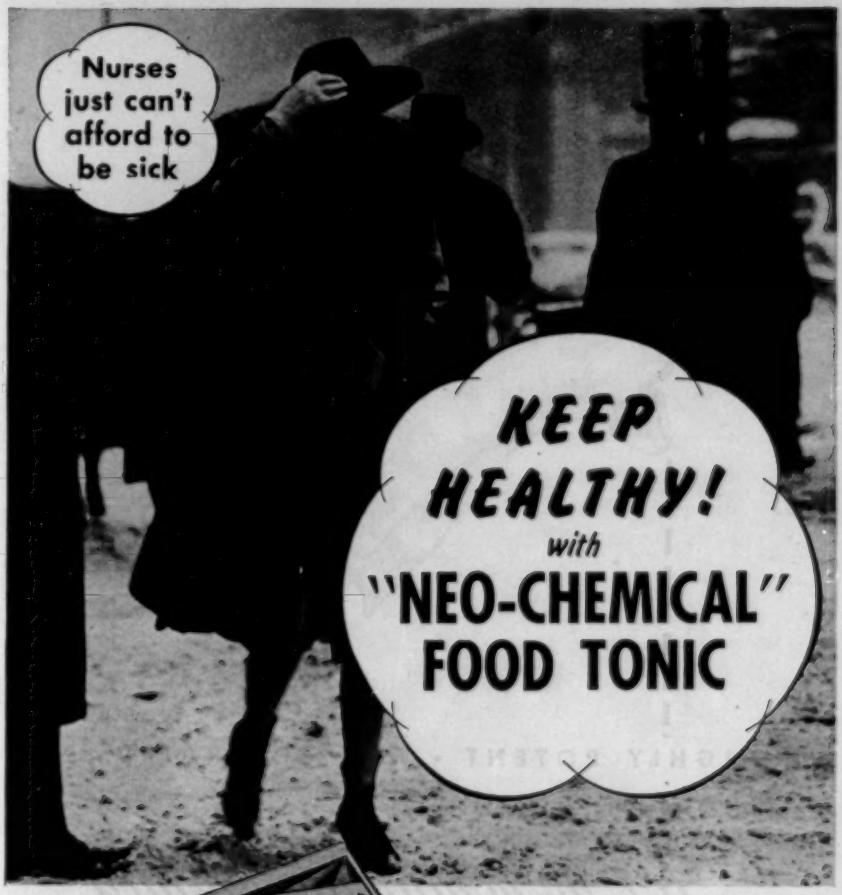
Dislocation of the hip is probably one of the most common of congenital deformities. It occurs six times as frequently in girls as in boys and is more commonly unilateral than bilateral. The earlier the defect is recognized, the more likelihood there is of effective repair. **Dr. W. G. Turner** has described the various methods of treatment that are used to correct this dislocation and **Flora M. Lamont's** outline of the subsequent nursing care will prove a valuable guide to nurses.

Should the supervision of venereal disease patients be carried on by a specialized group of workers or should it be incorporated into the generalized program of the official public health nursing organizations? **G. E. MacNeil** presents some forceful arguments for its inclusion in the latter program.

What does adequate supervision entail in terms of nursing services in our hospitals? **Sister M. Rosarie** has given us a very detailed analysis of the responsibilities which are inherent in each of the many positions in our modern school of nursing. So finely has she broken down the duties for each category that it made an article too long for publication in a single issue. Look for the other half on the Institutional Nursing Page next month.

The success of the prenatal classes which are a regular part of the public health program in Toronto should prove a stimulus to other communities. **Mrs. Maud Stapley** has given a general outline of the class content and has described the steps in organization. Not only is this a valuable way to ensure a healthy, happy, informed group of mothers, it is also a most useful means of acquainting the community with the nursing services that are available to them. We hope that there will be many more "combined operations" organized across Canada.

When the subscription rates were increased last October, we felt sure that there would be some unfavorable repercussions and an epidemic of non-renewals. To offset the latter as much as possible, the Executive Committee of the C.N.A. has endorsed the proposal of the Editorial Board that a **5 per cent commission** be paid on all new or renewed subscriptions at the graduate nurses' rates secured and sent in by the chapters, alumnae associations, etc., across Canada. This, therefore, is an official announcement of this policy. We would suggest that each organization designate a representative to whom subscriptions may be paid. It is scarcely necessary to mention that it is important that the convener should herself be a subscriber. How can she know the value of the *Journal* to others if she does not subscribe to it herself? This is an opportunity for each organization to augment its funds and at the same time be of real assistance to *The Canadian Nurse*.



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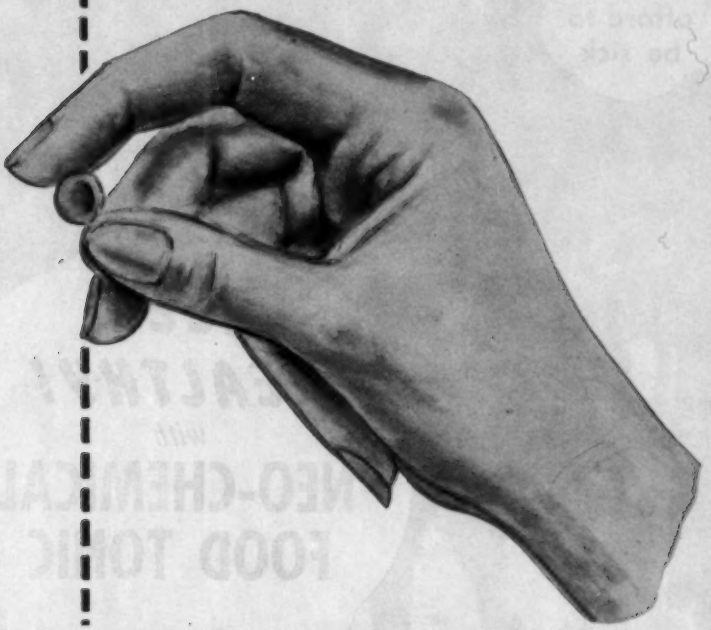

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References:

1. J.A.M.A., 128:490, 1945.
2. West. J. Surg. Obst. & Gyn., 51:150, 1943.
3. Am. J. Obst. & Gyn., 48:510, 1944.
4. Clin. Med. & Surg., 46:327, 1939.

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-FOUR *NUMBER TWO*

MONTREAL, FEBRUARY, 1948

Where There is Smoke

SEVERAL months ago the "Etiquette" column of a Canadian daily newspaper carried an item on, of all things, the *tipping of nurses*. The enquirer stated that after the private duty nurses had been dismissed, the patient found that the floor nurses who cared for her "were quite nasty because she couldn't afford to tip them." Very sensibly the author of the column replied, "It is never necessary to tip nurses, and they do not expect it, either from public ward or private room patients."

Not long ago we visited a friend who was recovering from a minor operation in hospital. To our consternation she asked, "How much should I tip each of the nurses when I leave?" On being assured that tips were not only unnecessary but would be refused by the nurses, our friend expressed disbelief and surprise. "Maybe the student nurses are not allowed to accept it, but the graduate nurses would think I was queer if I didn't offer them a few dollars extra," said she.

This series of incidents was capped by a letter which we received from a retired nurse who had been hospitalized for a brief period. She wrote, "On the day of my discharge from hospital, the young student who had been making my bed hung around waiting for a tip. Yes. I did not believe my senses at first, but the dawdling was carried to such length, was continued so long, that the ugly fact was obvious. I did feel ashamed for her!"

After receiving this blast to long cherished ideals, we wondered if we were out of touch with modern practices in hospital — if this was an example of "where there is smoke, there must be fire." One isolated instance does not carry weight but with three in as many months, in widely separated communities, could there be some foundation in fact? Were nurses, even a few nurses, so transparently expecting some form of gratuity for the services performed, that the general public, whom we serve, felt embarrassment, felt that they must "tip" us as they tip the bell-hop, the taxi-driver, the messenger boy?

What are nurses taught in their

earliest days of training on this matter? Aikens, in her "Ethics for Nurses," says:

The custom of nurses taking money from the sick in return for extra service rendered to them was one of the intolerable abuses in the days before trained nursing began. One of the important and sweeping reforms that followed as a result of Florence Nightingale's work and ideals for nurses was the abolition of this custom. Nurses of today occasionally are confronted with this old temptation to accept money from patients, while all reputable training schools have stringent rules against the practice.

That is a definite, concise reiteration of a principle that is so well known, so much an accepted part of our ethical background that it seems curious that any patient should even suggest it to a nurse. We have been urging nurses to "start talking," to inform the public of our hopes and aspirations. Perhaps we might commence with this topic. It is true that graduate nurses are entitled to adequate remuneration for the services they provide, but they do not want and, we believe, will rarely accept "tips." It is not difficult to imagine what effect a return to the general practice of this custom by all nurses would have on the tone and general reputation of our hospitals. Let us put out this particular "fire" of criticism, speedily and honestly.

Pioneer Nursing

Editor's Note: Do you think that you are over worked today? Read this entertaining account of a student's life at the Winnipeg General Hospital fifty years ago, before you complain again. Not that we recommend a return to such primitive conditions!

There is some uncertainty as to the authorship of this historic material. It may have been written by Miss Sarita Picken. Miss Birtles' name has been suggested as an alternate. Any clue that would establish the authorship would be gratefully received.

On page 141, there is an interesting list of the lecture headings and hours devoted to the education of nurses at the P.E.I. Hospital, Charlottetown, in 1891-92. Even nursing assistants get a more thorough grounding today!

NURSING in hospitals is vastly different today from what it was fifty years ago. In 1886, there were only a few hospitals in Canada — Toronto, Montreal, St. Catharines, Winnipeg, and one small miner's hospital at Nanaimo, B.C., etc. There was only one training school in Toronto. Winnipeg General was established in 1887.

I arrived at the hospital on July 1, 1886. I was told the next day at noon to go to bed to be ready for night duty at 7 p.m. Up to that time I had only seen one sick person and had never sat up a whole night through. Bewilderment seemed to take possession of me, which kept me awake. There were five patients, women, in a ward of sixteen beds, and two private rooms. Before going on duty, my sister, who had entered the hospital three months previously, gave me a few instructions; one was to remember I must not expect to be told a second time to do anything, and if I should be present at an operation I mustn't faint otherwise I would be disgraced forever. One of the patients in the public ward, a very sick woman, required dressings to be changed quite frequently. The night supervisor, Miss Orr, a Toronto graduate, came up to attend to her. I stood by watching every movement intently so that I would remember what to do next time it had to be done, which was in about two hours. I set about doing it as far as I could remember, exactly as Miss Orr had done it, and was just

(*Continued on page 126*)

Congenital Dislocation of the Hip

W. G. Turner, M.D.

The problem of the cure of this condition has been a constant study since 1895. Prior to that time, treatment had been a consistent failure. Some cases had been reduced but relapsed, as no method of retention had been established. In 1895, Lorenz of Vienna made his first contribution. His complete work was published in 1900. This was on the pathology and treatment of congenital dislocation of the hip. His method was the reduction by closed method and the retention of the head in the acetabulum by special posture in plaster, the position being the one neutral to muscle pull, i.e., with the hip in flexion and 90° abduction. These results awakened world interest. About the same time, Hoffa of Berlin published his work on the open reduction. The Lorenz method was adopted throughout the world and has persisted with certain modifications.

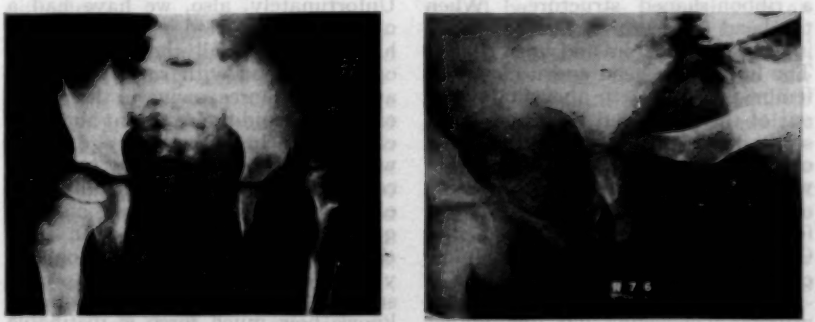
Etiology: The condition is usually present at birth and is regarded as a primary deformity. At times other deformities are associated, such as clubfeet and spina bifida. About 80-90 per cent occur in female children and unilateral cases are twice as frequent as bilateral.

Dr. Turner is chief surgeon at the Shriners' Hospital for Crippled Children in Montreal.

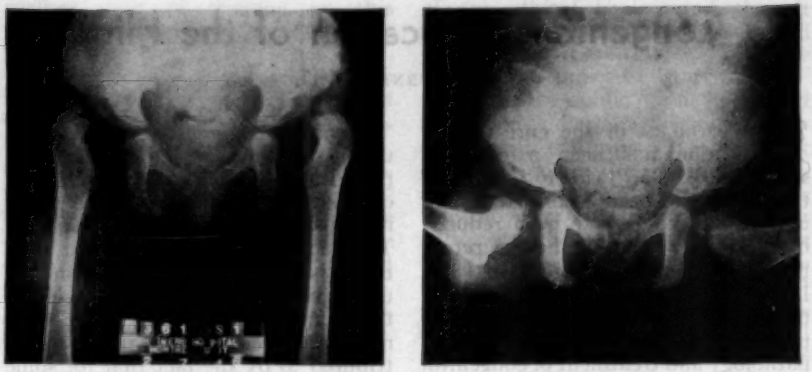
Pathological anatomy: The luxation usually occurs during intrauterine period and the head may be anterior or posterior to the joint. The posterior position is much more frequent. The acetabulum is flattened and there is frequently a defect in the upper rim. The head and neck of the femur are usually altered in their relation. These changes may be contributed to by the fact that for some time during development the head is not in the joint and normal joint function is not present.

Unless the reduction is made and retained, the joint cavity flattens and the head rides progressively upwards, and at the same time stretches and narrows the capsule. The upward progression may be for two or three inches or more. The result is a marked, unstable limp in single joint cases and a marked waddle in bilateral cases. Owing to this abnormal anatomy, there follows the gradual development of a marked lumbar lordosis.

Reduction: For a number of years, the closed method of reduction was preferred. Many orthopedic surgeons developed great dexterity in the reduction and, although using force, avoided all violence and leverage which would endanger the viability of the head. This was essential, and when strength was employed it



Single Congenital Dislocation — Before and after reduction



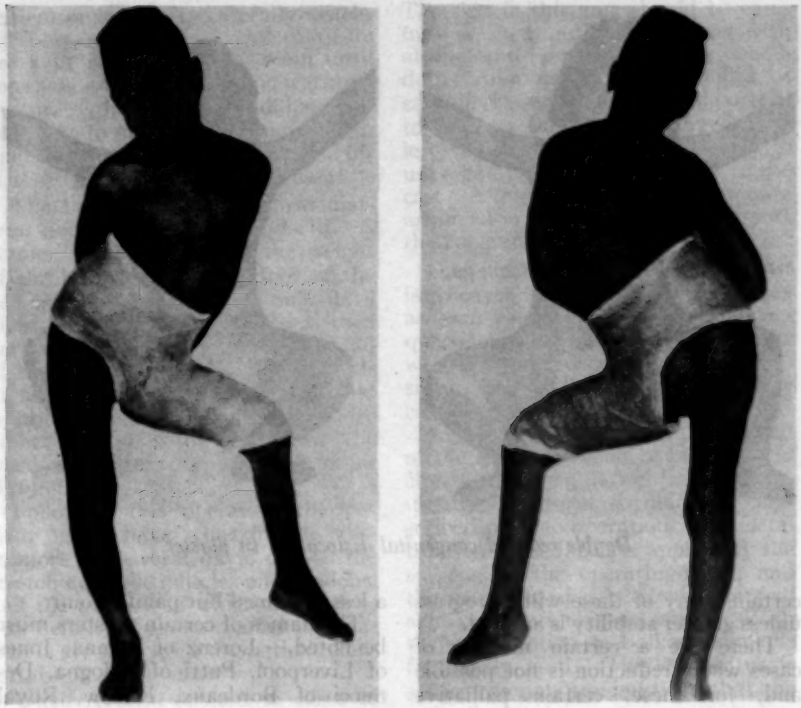
Double Congenital Dislocation — Before and after reduction

was with traction on the flexed and abducted hip, in order to bring the head into the joint by lifting the trochanter. Unnecessary violence would bruise the head and readily cause osteochondritis of the joint.

However, a certain percentage of failures following reduction persisted, especially after four or five years of age. The open reduction was more and more carefully studied and is now more extensively practised. The open reduction should never mutilate the capsule and the reduction must be performed in a gentle manner without any violence. We know that the capsule contributes to the viability of the head, and must be conserved as much as possible. The obstructions to the reduction are the changes in the capsule: narrowing, hourglass, adhesions, and a ribbon-shaped structure. When the head rides up, it causes shortening of the adductors and knee flexors. The line of the head and neck of the femur is frequently abnormal when out of the joint, and this contributes some difficulty. Naturally in older cases, as the head goes further upwards, there is increased shortening of the above muscles as also the femoral vessels and sciatic nerve. Careful x-rays must be taken in all cases, before and after reduction.

Diagnosis: This is unusual until walking has begun and the mother notes a painless limp. At times these patients are a little late in walking. The children are usually bright and well nourished. Painless limp in single cases and a waddle in bilateral cases are very suggestive. Usually, all movements are free and painless, but abduction is limited. It is easy to see the upriding of the trochanter. As age progresses, and the case is neglected, all these signs become more pronounced. Coxa vara and pathological dislocation must be excluded in the diagnosis. The latter is less mobile, owing to scar formation and the epiphysis has usually been affected. The x-ray film clearly establishes the diagnosis.

Treatment: Replace the head in the joint and retain it there. This is not as simple as the pure statement. At the Shriners' Hospital we have had all types of this deformity. Unfortunately, also, we have had a number of neglected cases, and these have presented all the problems of open reduction with some successes, and some failures, owing to the height of the head and the resultant anatomical changes. In the younger age group, we are encouraged by a certain percentage of success. Naturally, the older group and some young ones require the open reduction. In both the closed and open reduction, no violence should be used and proper surgical judgment triumphs, when it knows how much force is justifiable and when to stop. We try to have



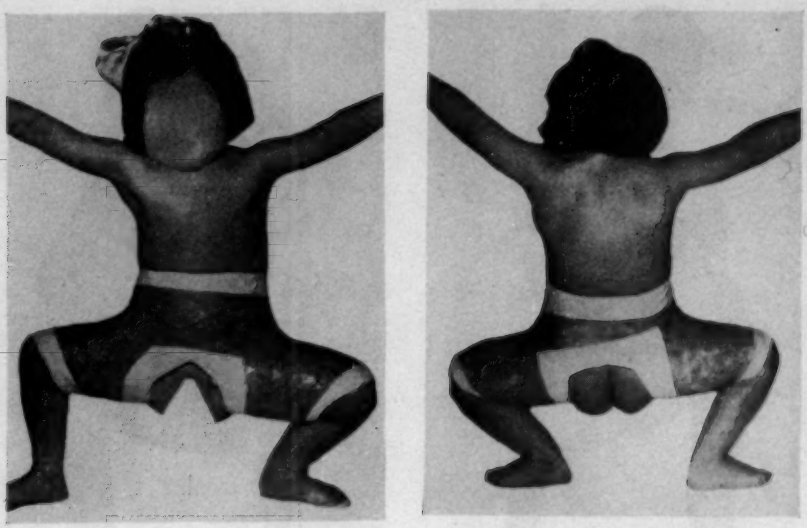
Single reduced hip in plaster

the children trained in toilet habits before reduction, but if this is too slow we go on with the reduction and plaster fixation. By raising the head of the cot or putting the child upon a frame, considerable soiling of the plaster is avoided, and when combined with good nursing we have little difficulty.

The *complications* arising from violence in reduction are very grave, and must be avoided. Prior to manipulation, the surgeon should judge whether preliminary traction should be done in order to loosen or stretch the periarticular structures. The importance of gentleness in reduction has been emphasized by Denucci and others, whose results in a large series of cases have been very good. The operator not only reduces the hip, but will also apply the proper plaster fixation and check by x-ray through the plaster before the case leaves the hospital. The application of a proper plaster fixation is nearly as important as the reduction. Plaster must be cut so as to allow for easy care for stool and urine, and there must always be full co-operation with the nursing staff in the care of these patients. A complete review every three months should be done — preferably as an in-patient. When the head is stable, careful physiotherapy is essential, especially pool therapy. At the Shriners' Hospital this is a requisite for some time before free weight bearing is allowed.

In providing post-operative care after open reduction the nurse must be especially vigilant, and each case is really an individual problem.

For redislocation with a shallow acetabulum, reduction and shelving operation has a definite place. Shelving should be considered in many subluxation cases, as it is quite



Double reduced congenital dislocation in plaster

certain many of these will retrogress unless greater stability is assured.

There are a certain number of cases where reduction is not possible and, for these, certain palliative operations must be carefully studied. Surgical judgment is essential, as a painless deformed hip is better than a less deformed but painful joint.

The names of certain masters must be noted — Lorenz of Vienna, Jones of Liverpool, Putti of Bologna, Denucci of Bordeaux, Ridlow, Royal Whitman, Davis, Bradford and Soutter, as they built up the study and cure of the problem.

Nursing Care in Congenital Dislocation

FLORA M. LAMONT

AS DR. TURNER has stated in his article, the most desirable time for treatment of these cases is as soon as the child is trained in toilet habits. If hospital facilities permit, the patient is admitted a few days before treatment is begun. This period allows for the orientation of the young child to her new surroundings and friends. Every possible precaution should be taken that no part of the treatment will frighten the child. If the child is old enough to understand, a simple explanation of what is about to take place is given. Pre-operative saline enemata are given and the glucose intake is increased.

In the young child, under three or four years of age, the treatment is usually a closed reduction with plaster fixation. During the operation there may be considerable shock and the

Miss Lamont is assistant superintendent at the Shriners' Hospital for Crippled Children in Montreal.

patient must be very carefully watched post-operatively. All patients are kept in the recovery room until conscious and their condition warrants return to the ward. Sand bags are arranged to support the limb and to maintain the desired position. This is done while the surgeon is present.

The bed should have a firm mattress and fracture-board under it. A cradle is used to relieve the weight of the bed clothes. The foot of the bed may be elevated, but only until all signs of shock have passed, then lowered. The following day the head of the bed may be raised. This aids in keeping the cast dry, if the child is not completely trained. It also allows the child to see about the ward and later to play with other children.

Following this operation the patient may have considerable discomfort for several days, due to the stretching of the muscles and tendons, and the position in which the limb is now held by the cast. Sufficient sedation is given to keep the patient comfortable.

When Avertin is used in cases of closed reduction, the anesthetist frequently finds it unnecessary to administer any further anesthetics, e.g., nitrous oxide or Cyclopropane. In open reduction, however, this additional anesthesia is necessary. In either case dilute sodium and potassium phosphate solution, as developed by Dr. Wesley Bourne, is given by rectum for the purpose of alleviating what little acidosis is invariably produced. Intravenous therapy is given when indicated.

If the surgeon has used stockinette under the plaster, all rough edges are covered and the stockinette securely fixed in the wet plaster at the time of application. If, however, this is not done, all the edges of the cast should be carefully bound with adhesive as soon as the plaster is dry. Adhesive cut in small pieces, 2 inches long and ½ inch wide, applied so as to slightly overlap one another (petals) makes a very neat finish. The nurse should be able to place her finger-tips under the end of the cast. The skin in this area should be carefully washed and dried, rubbed with alcohol and powdered at least once a day. All pressure points should be carefully watched. It is important to observe whether the surgeon has left sufficient room for the child to use a bed-pan without accident to the cast. A folded blanket or pillows are arranged in such a way as to support the back and limbs at this time.

One means of protecting the cast is to cover it completely with Castex as soon as it is dry. A special lacquer is applied to this, which can be washed with soap and water, thus simplifying the problem of keeping the cast clean.

In older children where the head of the femur is found to be high and closed reduction is not satisfactory, usually some form of traction is prescribed prior to operation. If skeletal traction is used, this is applied by the surgeon in the operating-room, and the usual pre-anesthetic and surgical skin preparation is necessary. With skeletal traction a Balkan frame is frequently used. This apparatus is set up the day previously so that the prescribed weight may be attached as soon as the patient returns to bed. Certain details are to be observed in the general care:

Firm mattress, fracture-board, or Bradford frame. Foot of bed elevated. Counter traction used in form of perineal pads with long straps attached to head of bed. Care in moving patient or bed so that the wire will not slip. Sterile dressings at ends of wire kept in place and changed as necessary. Pull must be in correct line. Watch for any indication of infection from wire. Weights are increased gradually and may be one pound for each year of child's age. This general rule may be altered according to the child's condition.

If skin traction is used this is frequently applied by the nurse. Two types of Buck's Extension are commonly used:

Adhesive straps with buckles attached by reinforcements fixed by shoe-makers' eyelets.

Flannelette strip with buckle attached by surgical tape sewn down centre of flannelette.

In either case, the leg is shaved and painted with Tr. Benzoin Co. The tendo-achilles, internal malleolus and

external malleolus are carefully padded and bandaged with sheet wadding. In the adhesive type, the straps are applied directly to the skin. The adhesive is nicked on both sides to fit the contour of the leg. The buckle should come just to the internal and external malleolus. The strip on the inner surface of the leg should extend from the internal malleolus to 2 inches below the groin, and the outer side from the external malleolus to the greater trochanter.

In the flannelette type, the skin is painted with liquid glue (Ace Adherent) and the extension applied in the same way while the skin is wet. The leg is then bandaged from the toes to the thigh, leaving the heel exposed, using factory cotton or crepe bandage. The weights are not attached until twenty-four hours later. A padded foot-board is attached to the buckles and the pull is directly from this, thus preventing drop foot. The nurse should have a complete understanding of the principles underlying this type of treatment.

Particular care should be taken that there is no irritation from perineal pads. These must be removed for the use of the bedpan and carefully replaced. It may be necessary to use a "tie down" to keep the child in position on the Bradford frame. The patient may be allowed to sit up for her meals, thus having a little rest from this tiresome position. If the pull becomes too great, some weights may be removed for a time at night and replaced during the day. Urinary complications may develop and should be reported to the surgeon at once. Any soreness of the skin under the extension may necessitate removing it.

Extensions may be left on for three to four weeks depending upon the progress of the head of the femur. This is watched carefully by the surgeon and x-rays are taken at intervals with the weights on.

When open reduction or shelving is indicated, the extension is usually removed the day previously, and the area surgically prepared. In some cases the extension is re-applied extending to the knee only and the weights left on during the operation. A blood transfusion is given during the operation.

The pre-operative and post-operative care is similar to that mentioned above, with the exception of watching for any hemorrhage from the operative area.

A window is cut over the incision so that dressings may be done and the sutures removed. This is usually the house surgeon's responsibility. It is important that this window should be carefully replaced and, as soon as the incision is healed, securely fixed in place by a plaster bandage.

Following an open operation the patient is usually in a long spica cast with the leg in abduction. Great care must be taken in turning the post-operative patient, so that the limb will be held in the proper alignment, with complete support. If the condition is bilateral and a closed reduction has been done, the child is in "Frog position." She may be turned on her face for periods each day.

In closed cases the patient remains recumbent for about three weeks. She may then sit up in bed and later may sit on a small chair. The cast is removed in four to six months, and the patient allowed to walk. If the reduction is complete she may be discharged from hospital in three weeks, and the mother given detailed instructions as to home care. The patient should be reviewed in two months' time. In open cases these children require to be recumbent and in hospital for three to four months.

When the cast is finally removed, the limb is supported by sand bags and allowed to assume normal position gradually. The patient is then given physiotherapy treatments, including pool therapy. Occupational therapy is of great value throughout the long convalescent period to provide interest for the patient, increase her morale and, following the removal of the cast, to increase movement of the limb through some specific task. The early activity is usually confined to exercise without weight-bearing. Gradually it progresses

until the patient is allowed up with crutches and finally is allowed to bear her full weight. The nurse should guard against any undue fatigue during this period. The child's education should be continued as soon as her condition permits.

All patients are carefully followed through the out-patient department for several years.

The Constant Flame

EARDLEY BENEDICT

THE FLAME that flickered in the humid, fetid wards of Scutari, shaded by the sympathetic hand that held it, has lighted a thousand lamps in every country, bringing a host of Florence Nightingale's spiritual descendants to the aid and comfort of the sick. They are now legion, in the starched, white uniform that bespeaks assurance of their professional standing. And now they pause, on their present pinnacle, and ask, "What more can we do?", "How can we improve nursing care?", "How can we improve our situation as skilled and laborious members of an exacting profession?"

The eight-hour day, the fee, the rights and privileges and the duties of nurses are being studied by nurses themselves and by boards and committees in whose hands rest the smooth, the efficient, and the humane operation of hospitals and rest homes. Where will the boundary be drawn between nursing as hired labor and nursing as an ideal service?

Out of the mists of eighty-six years, there fell into my hands "Notes on Nursing" by Florence Nightingale, published in New York in 1860. It provides not only sound advice, most of which is still applicable today, but an insight into a clear, masculine, forthright sort of mind, capable of making and recording perceptive observations.

To me, Florence Nightingale dwelt somewhere in limbo until this clear-cut little book came along. Her little light was kept alive for years only by earnest sixth-graders who chose her biography as a subject for elevating oral compositions. Then the ideals of a persistent woman were stressed, overcoming obstacles of ignorance and prejudice by sheer goodness.

Then the debunkers, who flourished so rankly in the last two decades, came and tore the veil of maidenly sweetness from the Lady of the Lamp. The "facts" seemed entirely at variance with the legend. She became a great forceful, striding woman who, like Amy Lowell, smoked enormous black cigars while making her demands known in a strident voice, in speech studded with oaths. All that was left to the imagination was a sort of bull-dog, Churchillian creature, clad in long, dark, severe garments, placing her firm booted feet on the way she trod.

But, on reading her booklet, there emerges a keen, sometimes humorous person, whose comments are succinct and still of value to the would-be nurse. Her expositions of the rules of nursing and the explanations of why they are good rules show the mind of the natural teacher. Yet she does not presume to teach. She merely points the way for anyone who is responsible for the care of another's health. She does not deal with the technical aspect of nursing because: "These notes do not pretend to be a manual for nursing, any more than for cooking for the sick" because the writer "who has herself seen more of what may be called surgical nursing, i.e., practical manual nursing, than, perhaps, anyone in Europe, honestly believes that it is impossible to learn it from any book, and that it can only be tho-

roughly learnt in the wards of a hospital." Thus she struck the note for which she was to fight, for practical training for nurses so that they might become "helps instead of hindrances" to the doctors' work. As Sir William Osler later made the great stride forward in medical study, allowing the student to observe in the wards, so Florence Nightingale brought the whole body of nurses forward to where they might become members of a profession.

With her clarity of mind and abilities of expressive comment she would have made a matchless speaker at a women's club, had she deigned to engage in such nonsense. (She refers to certain women as "those who have brought upon themselves ill-health by over-pursuit of amusement, which they and their friends have most unhappily called intellectual activity.") In this present age her commonsense advice would have been accepted readily by a news syndicate and she would have gained a public somewhere between the respective followings of Miss Dix and Mrs. Roosevelt. She was as blunt as the former and as *au courant* as the latter. But I think she would have scorned such a livelihood. She refers to those writers of her day as "female ink-bottles" and scores them for not attempting to reform women's dress while they chatted so glibly about "woman's particular worth and missionariness."

The subject of dress to her is not a matter of charming arrangement but of convenience and modesty. In a chapter on the effects of noise on a patient she says, "The fidget of silk and of crinoline, the rattling of keys, the creaking of stays and of shoes, will do the patient more harm than all the medicines in the world will do him good." And again, "Compelled by her dress, every woman now either shuffles or waddles —." "Her skirts (and well if they do not throw down some piece of furniture) will at least brush against every article in the room as she moves." In a footnote, frank for the period in which it was written, she complains, "I wish, too, that people who wear crinoline could see the indecency of their own dress as other people see it. A respectable elderly lady stooping forward, invested in crinoline, exposes quite as much of her own person to the patient lying in the room as any opera dancer does on the stage."

Yet I think she must have chosen pleasant clothes for she is fully aware of the effect of cheery surroundings on a patient confined by a long illness.

Nursing, as an occupation, was recognized as an entity in her day though there was no standard in skill or knowledge. She disagrees with those persons who say, or write, that every woman makes a good nurse. "I believe, on the contrary, that the very elements of nursing are all but unknown."

In the census of 1851 there were 25,466 nurses listed as well as 39,139 domestic service nurses, (nurse maids, etc.). Of these latter, 508 were between five and ten years of age, 7,259 between ten and fifteen, and 10,355 between fifteen and twenty. Of the more professional group the largest numbers (11,263) were between fifty and sixty-five years of age showing that, as a means of livelihood, it was turned to by widows and other women of moderate or no means. One hundred and forty-seven of these professional nurses were over eighty-five years of age. It is to all these women, professional and domestic servants alike, as well as to mothers, sisters, aunts, and governesses, that this manual is addressed, not to teach them to be nurses but to make them "think how to nurse." There were other books in print on the same subject at the time but Florence Nightingale's wide experience, and her then nationally recognized place in the profession, make her an undisputed authority.

Her first chapter is in the nature of a bombshell for it demands fresh air for the patient. It even speaks of allowing night air into the sick-room. She asks, "What air can we breathe at night but night air? The choice is between pure night air from without and foul night air from within." She refers to an "intelligent,

humane house surgeon" who constantly opened windows in a ward even though physicians and surgeons closed them when going their rounds. Perhaps she thought him intelligent because he was in agreement with her on the subject of fresh air. Certainly she does not hesitate to censure the medical profession of the day when it falls below her standards of behavior.

Defiantly she states that no one ever caught a cold in bed *if* the windows were open, the doors closed, the patient warmed by a hot water bottle rather than an extra load of quilts and blankets, and the fire going. With contempt she refers to a contemporary leaflet on nursing which states that "with proper care it is very seldom that the windows cannot be opened twice in the day to admit fresh air from without." According to the indomitable Miss Nightingale the fresh air should be such that the nurse can feel it moving on her face when she is standing still.

She suffers for the poor patient who is put into a bed that has "been well slept," with three or four layers of unaired mattresses. Equally she worries for the sick man who is put into an "absolutely clean" room, meaning one that has been closed up, with damp cold sheets, shuttered windows, drawn draperies, and a boarded-up fireplace. She wished for some scientific instrument, as simple as a thermometer, that would register the state of the air in a room so that when it registered "horrid" people would open their windows gladly. Though many of her far-reaching wishes have been realized this one is still unfulfilled though modern air filters most nearly approach it. She applauded the doctor who lectured thus on fumigations: "Fumigations, gentlemen, are of essential importance. They make such an abominable smell they compel you to open the window."

Florence Nightingale was aware of the scientific research of the day and she accepted or rejected it only as it was proved by her own experience. She was aware of the importance of light, various, but nourishing diet though food was then divided into only two classifications, that which was "carboniferous" and that which was "nitrogenous." From observing many patients who yearned for some food that seemed entirely inappropriate she believed that the patient's stomach was the true indicator of what was a remedial diet. The nurse is urged to attend to the patient's "fancies." She states that nature shows that living chemistry is something different from the chemistry of the laboratory.

In spite of her open and enquiring mind she refused to accept the theory of contagion, of germ infection. She states that she has seen diseases spring up of themselves because of lack of air, or light, or proper diet. Her footnote on her own theory in this matter is interesting and reminds one of certain passages in the book of the Colleges of Unreason, in Butler's "Erewhon":

> Is it not living in a continual mistake to look upon diseases, as we do now, as separate entities, which *must* exist, like cats and dogs? instead of looking upon them as conditions, like a dirty and a clean condition, and just as much under our own control; or rather as the reactions of kindly nature, against the conditions in which we have placed ourselves.
>
> I was brought up, both by scientific men and ignorant women, distinctly to believe that smallpox, for instance, was a thing of which there was once a first specimen in the world, which went on propagating itself in a perpetual chain of descent, just as much as that there was a first dog, (or a first pair of dogs), and that smallpox would not begin itself any more than a new dog would begin without there having been a parent dog.
>
> Since then I have seen with my eyes and smelt with my nose smallpox growing up in first specimens, either in close rooms or in overcrowded wards, where it could not by any possibility have been "caught," but must have begun.
>
> Nay, more, I have seen diseases begin, grow up, and pass into one another. Now, dogs do not pass into cats.
>
> I have seen, for instance, with a little overcrowding, continued fever grow up; and with a little more, typhoid fever; and with a little more, typhus, and all in the same ward or hut.
>
> Would it not be far better, truer, and more

practical, if we looked upon disease in this light?

Was it her prime concern for the welfare of the patient that made her prefer her theory to the one of "infection" which was then becoming generally accepted and is now part of common belief? She asks, "Does not the popular idea of 'infection' involve that people should take greater care of themselves than of the patient?" Here is her touchstone. What is best for the patient? Her whole thought was for the sick, their comfort, their cure. Anything that interfered with their proper care she cast aside.

Of the rights of nurses she has little to say. There is nothing of wages or hours in her book. Here and there in the pages one finds mention of small privileges. They should be allowed to leave the patient at intervals for meals, rest, a change of scene. They should not be constantly responsible for a violent or delirious patient. They must have a position of authority in the household where they serve though it does not extend to "ordering about" the servants. But all these small privileges are merely to refresh them for their job. They are "musts" in order that the position may be filled with more vigor and interest.

But the nurse's duties and her responsibilities to her patient are those of a mother to her child. She must observe. "But if you cannot get the habit of observation one way or other, you had better give up the being a nurse, for it is not your calling, however kind and anxious you may be." Fresh air with warmth, nourishment without overfeeding, variety without confusion or excitement — all these are responsibilities, as well as accurate attention to pulse, temperature, appetite, and nervous strain. Her description of the doctor who enters on a weekly visit and asks, "Feeling better?", "Sleeping well?", "Good appetite?", and then leaves after receiving affirmative nods from the patient is still so frequently repeated today that it is, in its way, a masterpiece of reporting, as Robert Benchley's monologues became little classics in the last decade. She here puts the onus of informing the doctor of the true condition of the patient on the nurse, a service now performed by the chart kept by the nurses. She seems to understand thoroughly the desires and the abnormal imagination of the physically ill who himself does not contradict the doctor's cheery assumptions "sometimes from amiability, often from shyness, oftenest from langour."

Always the nurse must think and act for the patient. She must preserve him from tiring visitors. "How little the real sufferings of illness are known or understood. How little does anyone in good health fancy him or even *her*self into the life of a sick person." "Very few people, be they of what class they may, have any idea of the exquisite cleanliness required in the sickroom." "The well have a curious habit of forgetting that what is to them but a trifling inconvenience, to be patiently 'put up' with, is to the sick a source of suffering, delaying recovery, if not actually hastening death." "If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally the fault not of the disease, but of the nursing." "Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion."

If it is a whispered conversation in the same room, then it is absolutely cruel; for it is impossible that the patient's attention should not be involuntarily strained to hear. Walking on tip-toe, doing anything in the room very slowly, are injurious, for exactly the same reasons. A firm, quick, light step, a steady, quick hand are the desiderata; not the slow, lingering, shuffling foot, the timid, uncertain touch. Slowness is not gentleness, though it is often mistaken for such: quickness, lightness, and gentleness are quite compatible.

If you wait till your patients tell you, or remind you of these things, where is the use of their having a nurse? There are more shy than exacting patients, in all classes; and many a patient passes a bad night, time after time, rather than remind his nurse every night of all the things she has forgotte n

They don't want you to be lachrymose and whining with them, they like you to be fresh, and active and interested, but they cannot bear absence of mind, and they are so tired of advice and preaching they receive from everybody, no matter whom it is they see.

She knew, and recognized the difference between the really ill and the hypochondriac and dismissed the latter with a pungent paragraph subtitled, "Two new classes of patients peculiar to this generation."

Paragraphs like those quoted here, with which the book is studded, show, over and over, how alert Florence Nightingale was to every phase of nursing. Without once touching on the technicalities of administering drugs or treatments she creates the whole foundation of good medical care. Nothing that bears on the causes and cure of illness escapes her attention. One by one she deals with each evil of the day that contributed to poor health. Drains, sinks, water-closets, stables, gas-light, heavy draperies, thick carpets, unaired mattresses, bed flounces, closed rooms, noisy houses, talkative visitors — she seems to recognize all the factors that delay the cure. To her the medicines are not nearly as important as the kindly, thoughtful care of an intelligent woman.

On the subject of housing she projected herself far into the future, beyond even the generally accepted tenets of today's architects. In her desire for light, air, ventilation, plane surfaces, with no ledges to catch dust, she would do away with ornate trims and papered walls, (particularly green paper which had some arsenic compound in the dye) and substitute non-absorbent cement, glass or white tile for inner surfaces, and for outer walls, glazed brick, in order that houses could be washed down by a stream from a fire engine. To insurance companies she suggests that they inspect the premises in which an insured person lives, rather than the person himself, in order to judge his life expectancy.

This woman who had dared to go into the world that was then absolutely a male dominion, that of military activity, to aid the wounded, came out of terrifying experiences unhardened in any way but in her resolve to reform the current system. But the K.R.O. of the day even bound her outlook and she did not dare suggest that women enter this field. "Upon my own experience I stand, and I solemnly declare that I have seen or known of fatal accidents, such as suicides in delirium tremens, bleedings to death, dying patients dragged out of bed by drunken Medical Staff Corps men, and many other things less patent and striking, which would not have happened in London civil hospitals nursed by women . . . but were a trustworthy *woman* in charge of the ward, or set of wards, the thing would not, in all certainty, have happened . . . Let no one understand by this that female nurses ought to, or could be introduced in regimental hospitals. It would be most undesirable, even were it not impossible."

Would her stultifying Victorian modesty be outraged today by our nursing sisters in their beautiful, assuring uniforms, or would she be happy to see the men, for whom she poured out her own energies, even to withstanding criticism from her own class, cared for with all the skill and devotion that civilians receive? I think she would be happy that her own advice is applied so universally.

To the criticism to which she was subjected she turned a deaf ear. In her regard the profession of nursing stood second to none and always she maintained its nobility. How she lashes at the idea then held commonly by most men and many women "that it requires nothing but a disappointment in love, the want of an object, a general disgust, or incapacity for other things, to turn a woman into a good nurse."

"This," she adds, "reminds one of the parish where a stupid old man was set to be schoolmaster because he was past keeping the pigs."

She attacks the novelists of the day who create heroic nurses out of just such drawing-room ladies as she describes:

The everyday management of a large ward, let alone of a hospital . . . are not these matters of sufficient importance and difficulty to require learning by experience and careful enquiry, just as much as every other art? They do not come by inspiration to the lady disappointed in love, nor to the poor workhouse drudge hard up for a livelihood.

But of all the difficulties Florence Nightingale had to contend with the worst was the belief that her calling was unwomanly. Nursing was all very well for a woman, and her natural occupation as long as she did not try to learn secrets of health and disease that were beyond her female mind. She was fit to be a glorified domestic but not a professional person. The male mind refused to admit her into the intricacies of pathology. She dismisses all the critics with:

And, as a wise man has said, no one has ever done anything great or useful by listening to the voices from without.

You do not want the effect of your good things to be, "How wonderful for a *woman*!" nor would you be deterred from doing good things by hearing it said, "Yes, but she ought not to have done this, because it is not suitable for a woman." But you want to do the thing that is good, whether it is "suitable for a woman" or not.

A Health Week Project

LOIS C. KELLY

PUBLIC HEALTH nursing in the Porcupine Health Unit covers an area of approximately 180 square miles. It is in one of the very active centres of the Dominion, a country where artists delight to reproduce the beauties of winter and summer, where photographers recapture the scenes for permanency and where the young child is skilled on skates and skis at the age of five years.

The Porcupine Health Unit is situated in northern Ontario where seven thousand miners are daily employed tunnelling their way deep below the earth's surface to extract from the rock the precious yellow mineral: gold.

During National Health Week we had an excellent opportunity to participate in the national health program. After deciding upon our objectives, we outlined a definite plan designed to reach every one of the forty thousand population served by the health unit. It was encouraging to note the number of requests for material for programs which we received, indicating the interest of the public. This was the deciding factor which crystallized our arrangements.

Our objective was to make the public more health conscious, to stimulate the interest of the individual in his own health and well-being and that of the community as a whole. In an endeavor to reach everyone within our area, we felt our planning should include the home, school, and community, so a program was drawn up, sufficiently flexible to permit each public health nurse to adapt it to the particular needs of her own district. One of the department stores in the main shopping district of Timmins donated window space and gave the service of their window dresser to set up a display of "How the Porcupine Health Unit Serves You." A signpost, pointing to photographs, indicated the service given by public health nurses in a generalized public health program. Two manikins were used, one representing the public health nurse as she appears in the clinic and school, and the other as she is dressed for the district.

It was of particular interest to note the number of people who were attracted to the window display and to hear their casual remarks as they

Miss Kelly was public health nursing supervisor with the Porcupine (Ont.) Health Unit at the time this article was written.

viewed the photographs and discovered people and scenes with which they were familiar. The children were delighted to see the picture of "Our Nurse." One of the mothers proudly exclaimed, "That is my baby the doctor is immunizing." Still another mother was heard to say, "That is a terrible picture of me, but I never take a good picture anyway." Spot announcements concerning Health Week were broadcast over the store's sponsored radio program and reference was made to the window display. An attractive figure of a little boy sweeping vigorously was displayed in the front window of the Municipal Building under the heading "Let's Sweep Out Disease."

It was arranged that the opening of the Child Health Conference in its new quarters would take place during this week. A notification to this effect was sent to parents with an invitation to be present. The attendance was very gratifying.

One phase of our generalized program, a very important aspect, is the provision of prenatal care. In order to acquaint the public with the facilities that are provided for this service, two public health nurses put on a demonstration of a visit which took the form of an interview between a prospective mother, Mrs. Smith, and the public health nurse in her district. The interview was conducted in three acts, the public health nurse making excellent use of the Birth Atlas, which proves such a valuable aid in teaching. Many parents were impressed with the interview and expressed the opinion that all prospective mothers should know about and have the opportunity of receiving advice and information on prenatal care as given by the public health nurse.

The demonstration was given as part of a series of lectures to the mothers of the preschool group, the first lectures being scheduled to commence during Health Week. Although weather conditions were such that we were sure the mothers would not venture out, we were agreeably surprised when twelve arrived, bringing with them their children. The latter were left in the care of volunteers who supervised their play.

Let us visit a few schools and see how Health Week was vitalized for the school child. In the first classroom, forty-two beginners are just completing an art lesson. We view the finished product — the public health nurse in her car. While one might have some difficulty in distinguishing car from nurse, the efforts of each child call for admiration and praise. As we listen to several children talking in the familiar language of the six-year-old, we realize that these children have a friendly knowledge of the public health nurse. They know that her visits to the home and school are for the purpose of protecting their health and that of their families.

The public health nurse's office at this school was temporarily transformed into an art gallery in which were displayed the posters on health considered to be best from each of the grades. Each poster displayed originality and thought. A system of rotating posters from one classroom to another was successfully worked out by the teachers thus permitting each class to view the work of the others.

At another school the public health nurse, at the request of the principal, arranged to address various grades over the public address system choosing material suitable for each grade. As the dental inspection had just been completed for the beginners, she gave them a talk on "Jimmy Chew," illustrating her talk by little figures representing teeth. As she spoke these little figures seemed to become alive and, judging from the excellent attention given, one felt quite convinced that some of the toothbrushes lying idle at home would be brought into action again. Parents would be requested to have some of those green and yellow vegetables appear on the menu more frequently.

To stimulate interest in cleaning the teeth, after the dental inspection the Lions Club of Timmins presented each beginner with a tooth-brush and

case. Illustrated material was also given to each child showing the best method of brushing the teeth. This was followed by a Mickey Mouse certificate for those who qualified. If the teacher felt reasonably sure that a genuine effort was being made to follow instructions for care of the teeth, she presented the child with a certificate.

One little chap, eight years of age, came to the office of the health unit inquiring if he could obtain sufficient health literature to give some to each member of his class, for he was the speaker on health. He was delighted to receive little booklets suitable for his grade and with both arms full he started for school. Judging by his enthusiasm we are sure that his speech went "over big."

We feel that the instruction given by the teachers and the public health nurse in the schools is helping to vitalize health and to stimulate the pupil's interest and desire for healthful living, an excellent foundation for present and future years.

The press was very generous in donating space in its daily paper and one page was devoted to articles and photos relating to our health program.

A radio skit was prepared by the public health nurse and broadcast over the air. A number of clubs were addressed by members of the staff during the week and a talk was given to the high school on nursing as a vocation. The health officer addressed groups on cancer.

Thus drew to conclusion what we believe was a successful week. The ultimate results, however, can be judged only by the continued interest of the individual every one of the fifty-two weeks in the year.

Dangers in Outdoor Sports

Outdoor sports are extremely popular among men, young and old. These forms of recreation, beyond question, return large dividends in improved health. Too frequently, however, the hazards associated with sports are forgotten or disregarded by those bent on pleasure, with serious and even fatal results.

According to information compiled by the Metropolitan Life Insurance Company, published in their *Statistical Bulletin*, most of the fatalities from outdoor sports, about 70 per cent of the total, were accounted for by three sports — hunting, fishing, and swimming. Hunting alone was responsible for a little more than 10 per cent of all deaths from outdoor sports. As one would expect, a very considerable proportion of deaths in hunting accidents, about three-fourths, were due to wounds inflicted by the discharge of firearms either by the injured person or by another. It is apparent from the details regarding the accidents, given on the death claim records, that many of the men who go hunting know little or care little about the proper handling of a gun.

Fishing took more than twice as many lives among men as did hunting. Of the fatalities attributed to fishing accidents, almost two-thirds were the result of drownings involving mishaps in small boats. The need to know more about handling small boats and acting safely while in them is not limited to fishermen and hunters.

A number of persons were drowned in mishaps while merely rowing, canoeing, or cruising about in small boats for pleasure.

Swimming and bathing, of all sports, claimed the largest number of lives, accounting for more than one-third of all lives lost in such pursuits.

The relatively heavy death toll from swimming each year reflects in large part the popularity of the sport in our country. It also points to the fact that very large numbers who go into the water either to swim or to bathe are poor swimmers or non-swimmers. While they contribute heavily to the loss of life, the toll each year is augmented by many drownings among good swimmers who attempt feats beyond their strength. In addition to those drowned, a considerable number of swimmers die annually as a result of skull fractures, broken necks, or other injuries they receive in diving accidents.

It is not expected nor is it desirable that, because of the hazards involved, men forego the pleasure and relaxation that outdoor sports afford. But every effort should be made to acquaint sportsmen with the chief dangers they may encounter and with the best methods to guard against or overcome them.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Value of Adequate Supervision

SISTER M. ROSARIE

SUPERVISION is a recognized function in the educational growth of all people and it is essential in all fields of professional service. Organization, administration, teaching and supervision become significant only when their effect is felt in service. Therefore, the ability and capacity to enlarge the scope and improve the quality of service rendered, through increasing the efficiency of the nursing staff, is what the term supervision in nursing implies. *To give to the staff is to get in service.*

The aim of supervision in nursing is to promote the professional growth of students and graduates. Its fundamental principles are based on the democratic philosophy of education, which is "Growth through guidance." Supervision is an art become fruitful through the use of effective techniques and through the influence of personality. It utilizes scientific principles of administration and teaching. The complementary nature of the scientific principles of supervision and its democratic ideals brings about their unity in the function of supervision as an art. Its scientific facts govern the process of supervision. Its philosophy sets the aims and determines the values of experience for the good of the worker and the work. Much of the supervision that one observes today is too vague and indefinite, and too incidental to be really helpful and productive. The plea is not for less science in supervision but for more art. The final evaluation is in the skill of performance. Supervision is first and foremost an educational function and the modern aim in this regard is to develop the capacity of the supervised so that they may meet their responsibilities in a more productive way. The improvement of human, individual, and scientific nursing care of patients and of the clinical teaching of nurses is the sum total of supervision in nursing.

Supervision has been defined as "over-seeing" or as "higher vision." It consists of all those activities by which supervisors, directors of nursing education, or ward supervisors may express leadership in the improvement of learning and teaching of nursing care and of nursing service. In nursing education, supervision has arisen as a safeguard in a busy system. Supervision is an accepted business principle in any complex human undertaking; that is, any undertaking in which several people are working together needs unification and co-ordination. It must be a clearly defined, definitely organized program, scientifically and education-

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ally sound and capable of improving the clinical instruction of nurses and the human, individual, and scientific nursing care of patients. Supervision is not merely inspection, far from it, and should it become so, it should serve as a basis for a teaching situation. Through proper supervision one aims at enlarging the abilities of those supervised. There must be a co-operative understanding between students, head nurses, supervisors, and instructors which must parallel or supersede the accepted standards of the hospital or organization and enable the workers to function successfully on accepted standards.

Above all, supervision must remain democratic. Modern discipline is based on intelligence and discretion. Modern psychology points out that *leading* not *bossing* is the more effective method. The focus of attention is now upon the development of the *person* rather than the *work*. This approach is recommended because improvement in the service can be brought about only by promoting the growth and increasing the ability of the individual concerned. Individual differences, potentialities, and special abilities are recognized in directing and guiding the process of educational growth. Therefore teaching and supervision cannot be separated in function. They are part and parcel of one educative process; the teacher must supervise and the supervisor must teach. Supervision is a guiding force in the promotion of educational growth and modern supervision aptly fulfils its function in the fields of education and service by virtue of its democratic philosophy, its scientific approach, and its artistic performance.

General Floor Duty

It is in this service that nurses develop the traits and abilities of the good nurse. General duty nursing includes the administration of curative, preventive and health measures; the caring for the general hygiene (health) of the patient and treating the condition of illness (treatments, medications, etc.) at the same time.

Nursing is a profession for public service. It has a *social* function in its human relationships. It has a *service* function in caring for the sick. It has an *educational* function in the promotion of health and in the prevention of disease. It has a *research* function, not always recognized in the accurate keeping of records and the observation of symptoms. It is *indispensable to medical investigation*, as it endeavors to determine the cause and the cure of disease. Thus nurses on general floor duty have a responsibility to meet and a contribution to make to the hospital, the nursing profession, and to society. Intelligent and efficient service is required of those on general floor duty. Obligations and responsibility must be met in a capable manner and in accord with proper supervision.

Graduate nurses on general floor duty have no direct but much indirect responsibility for the educational program. Although they are engaged for nursing service, their presence, attitude, and manner of working have a definite influence upon the students with whom they come in contact on the wards. From this point of view it is important to select graduates who display a wholesome attitude toward their work and toward the nursing school. General duty nurses should be included in the staff education program and their work should be made as interesting and progressive as possible. Graduates employed as general duty nurses must abide by the same rules and regulations as govern the student nurses while on duty. On very few wards can an all student nursing staff provide satisfactory nursing care. The quality of nursing care noticeably improves when some graduates are added for general floor duty. When graduates supplement the student group on the floor the whole educational program for the undergraduates can be planned and carried out more effectively.

Students working with graduates on the ward should be able to turn to them with confidence and assurance

when problems too difficult for their inexperience present themselves. Group conferences should be planned for these graduates as well as for the student body. At these meetings, problems in relation to their particular ward can be discussed, new procedures and routines demonstrated, and other matters of special interest to this group discussed.

Supervision of general floor duty nurses must be planned and executed as carefully as for the student group. The head nurse has very definite professional responsibilities toward these nurses. She depends on them for a high quality of nursing service and she should remind them that students look up to them as models and imitate them. Consequently, nothing but the best type of work should be accepted from them. If these graduates come from different hospitals, they should be made familiar with all routines and procedures as carried out on the ward. The nursing practice must be unified and the staff on general floor duty should adapt itself to existing methods and situations. Those on general floor duty should continue to learn through daily supervision. Experience as a staff nurse is considered fundamental for every head nurse. Therefore administrative and teaching responsibilities should be delegated to those graduates on general duty who prove capable of assuming them. Valuable experience is gained by competent graduates in this way under the guidance and careful direction of a good supervisor. Co-operation with other staff members, emotional stability, together with a pleasing personality are essential to ensure good working relationships and the maintenance of satisfactory administration for those on general floor duty.

Private Duty Nurse

Private duty nurses are likely to have much the same professional interests and ambitions as general staff nurses. Their range of patients may be more restricted but they have abundant opportunities to gain new experience, especially when they are caring for patients in a hospital. With the help of institutional libraries and through conferences with physicians and technicians, they have ample means of studying their individual patients. Private duty nurses should avail themselves of every opportunity to advance in their profession. While heads of departments do not wish to impose a plan of study on private duty nurses, they may, nevertheless, call their attention to special phases of the staff education program and arouse their interest for further development and growth in their respective field.

The same sound supervision which governs general floor duty nurses applies to special nurses. The maintenance of the same professional standards as are held up to students and those on general staff duty should be met by those engaged in private duty. One of the difficulties in supervising a group of experienced graduates is that they may not realize their professional shortcomings and may not see the importance of the small details exacted from students and those on general duty. Here, the supervision must be tempered with firmness and consideration. Those supervising this senior group must be well versed in their own specialties. They should understand the psychology of the graduate group under supervision and be able to present their subjects and instructions to them in such a manner as to interest them and utilize their background of experience. Leadership controls and wins this particular group of nurses whereas bossiness causes annoyance and resentment. Diplomacy is the keynote of maintaining good discipline and cooperative relationship among private duty nurses. A respectful and professional attitude toward the hospital personnel at all times is required of those engaged in private duty nursing.

Punctuality in administering medicines, treatments, etc., is of prime importance. Private duty nurses are expected to give expert bedside nursing care; to solve nursing problems

successfully; to adjust to patients' needs; to create a pleasant atmosphere in the sickroom. They should strive to alleviate anxiety and worry on the part of the patient and to promote a hopeful and encouraging spirit. They must assist the patient to make the necessary adjustments during each stage of illness and recovery, and to assist and co-operate with doctors and others who contribute to the welfare of the patient.

Head Nurse

The head nurse holds a key position in that she is the closest to the students in their practice field and is also in direct contact with patients and the medical staff. In conjunction with the supervisor, she is responsible for the nursing care and for assisting in carrying out the ward teaching program. Efficiency, together with a tolerant sympathy and tactfulness, will tend to promote a sense of confidence and security in both students and patients. The influence of the head nurse tends to foster or destroy the spirit and attitude of the students in regard to nursing. Preliminary experience in private duty is valuable and helps to convey a sympathetic understanding of patients to relatives and friends. She should unquestionably have a general knowledge of ward administration and teaching.

The hospital is the temporary home for patients and, therefore, they are guests of the institution. The head nurse serves as hostess for the hospital. She should try, if possible, to be on hand when patients are admitted to her ward. She should introduce herself and identify herself as the one in charge. The first interview can do much to give a patient a feeling of confidence in the personnel and a sense of security in the institution. Following the first interview, the head nurse is expected to see her patients often enough to know their conditions, to note the effectiveness of their care and how they are adjusting to the hospital and personnel. Likewise upon discharge, if during her hours on duty, she should make sure that the patient is properly clothed and that suitable conveyance is provided, even when private nurses are caring for the patient.

The volume of work in each hospital unit should be kept flowing evenly, smoothly, and steadily in spite of interruptions and irregularities. Each head nurse will have her own plan for successful management but, as a rule, she begins her day by conferring with the night nurse before the day staff arrives. On the basis of this advance information and the morning report, she delegates the work of her staff. Requisitions are revised, time schedules adjusted, supplies are checked, repairs attended to, routine observed, and the food service supervised. Activities must be arranged and co-ordinated in order that time and energy as well as supplies may be conserved. Emergencies must be met as they arise. Inquiring relatives and friends must be treated with interest and politeness, despite the rush of work, and organized and planned programs must be kept, in order that the staff finishes work on schedule. If there are student nurses engaged on the ward, the head nurse, as a member of the faculty, will have additional educational functions.

The position of head nurse is unique in the number and kinds of activities represented and the variety of its human contacts. She should reflect the hospitality and humanity, as well as the efficiency of the hospital. A gracious and capable attitude toward business, professional, and social relationships is her greatest asset. Such competent supervision on the part of the head nurse will have an actual therapeutic effect on the patient and also react beneficially on the hospital and will make the wheels run more smoothly in the organization as a whole. Co-operation with the superintendent of the hospital, the superintendent of nurses, the administrative executive, the school of nursing faculty, and members of the floor and department personnel is primarily essential to good organization and super-

vision. The importance of this "working-together" spirit cannot be overemphasized. The head nurse who has to deal with students on her ward service must co-operate with the educational director as to the arrangement of classes, lectures, etc. Nevertheless, the ward must not be left without sufficient and reliable help during class hours. The planning and organizing of this most important phase of supervision is left to the head nurse.

In order for any organization to function smoothly and efficiently, provision must be made for the flow of authority from the head to each worker in the unit. Satisfactory unity of plans and co-ordination of action can only take place when the ultimate responsibility for their success lies in the hands of a single individual. On the ward the head nurse is this person. The ability to delegate authority is one characteristic of a good administrator and after the assignment has been made she should not interfere in its execution, unless asked to by the delegated person. There should not be any lack of definiteness in the assignment of duties as this creates confusion and is a frequent source of inefficiency. All assignments should, nevertheless, be checked by the head nurse when completed. Individual differences must be considered, their needs studied, and help given accordingly, if each member of the staff is to develop in acceptable ways.

Because of her ability to control and run her ward smoothly and efficiently and because of her professional knowledge and experience, each member of her staff looks to her for guidance. In many situations there are so many administrative duties to be executed that only by sound planning and skilful manipulation can the difficult role of a capable head nurse be fulfilled.

(To be concluded next month)

Canadian Appeal for Children

CLARE M. SLATER

Today in many of the countries that gave birth to the greatest discoveries in medical history, even the simplest material for teaching future doctors and nurses is unavailable; the most uncomplicated surgical instruments are completely absent and, above all, the men and women who were qualified professionally to teach the younger generation were "exterminated." When the enemy occupied these countries in Europe, they started to destroy all those persons who by reason of their intelligence or training could act as a focal point for reconstruction after war, or for resistance during it. Naturally, with the hospitals full of highly trained specialists, technicians, and nurses, it was logical for the Germans to destroy them systematically and ruthlessly — buildings, staff and patients alike. Hoping, as they did, to leave the occupied countries after the war in a state where their intellectual reconstruction would be virtually impossible, they paid a rather macabre compliment to the nursing profession by placing them high on their liquidation lists. In one town in Poland, for example, they rooted out and killed all the leading citizens of the town, over eight hundred of them — doctors, nurses, teachers, clergy and, in fact, anyone who had shown any ability for leadership. These men and women were buried in a common grave, as a lesson to others who might follow and try to lead the conquered nations again to freedom and democracy.

Possibly one of the best examples of the depths to which medical practice has been forced in many of these countries was given

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when an American agency sent over large quantities of penicillin for the hospitals. This remained unused for a long period of time and, when the agency investigated this strange occurrence, it was found that none of the doctors or nurses had even heard of the drug, and so were unable to put it into use among their needy patients. Probably the medical profession of Europe, if it could plead for itself, would ask first of all for newer knowledge and then for equipment. During the eight years of the war, while these countries were at a scientific standstill, this continent and Great Britain pioneered in the use of many drugs, chemicals, and new techniques that have proved of great value to the world. To the medical profession of Europe those eight years are in most cases a blank wall.

We all realize that Europe is hungry and cold; that their first need is for food and clothing for their bodies. We often forget that almost equally important are their hungry minds. We look to the lands from which great and wonderful contributions to the world's learning have come in years gone by, for leadership in our efforts to attain a world which will be at peace, and where understanding and co-operation are universal. The young people to whom we turn for this leadership are being thwarted in their efforts to obtain even the most elementary education, while those who would like to have the training that could fit them to be the doctors and nurses of tomorrow might as well almost forget these aims now. Their classrooms are without even chairs and tables; books are practically non-existent. Simple chemical apparatus is unobtainable at any price; microscopes and other equipment are things of the past.

Clearly it is our duty to do something about all this and it is for that reason the Canadian Appeal for Children has been launched.

The Canadian Appeal for Children, which will open in February, is jointly sponsored by the Canadian Council for Reconstruction through UNESCO and the United Nations Appeal for Children, and is the only voluntary international relief agency in this country. It has the approval of the Canadian Government and His Excellency Viscount Alexander has consented to be its Honorary Patron. Its objective is two-fold: providing food and clothing to the war-orphans of Europe and Asia; and giving material aid for reconstruction in the educational, scientific, and cultural fields. Since most basic materials are required in such large quantities, the main emphasis of the appeal is for funds so that these articles may be purchased in wholesale lots, but to the nursing profession the request is for material aid as well. Older editions of standard textbooks used in nursing schools, sets of professional nursing journals, and other technical publications are urgently requested and by donating duplicate sets and back numbers of these publications nurses can help a great deal. We cannot feel that by our support of this appeal a New World will suddenly appear — free from hunger and want, educated, intelligent, and internationally-minded. We can feel that we have the means at our disposal to put test-tubes into the hands of a coming Lister or a microscope into the eager hands of a future Pasteur.

In giving your fullest support to the Canadian Appeal for Children you are reaffirming your belief in the principles laid down by Florence Nightingale — that in helping your fellows in other countries to rebuild their nursing schools and hospitals, you are giving them the tools with which to help us build strong and healthy nations.

℞ *Chuckles* P.R.N.

If the medicine is an oil, the patient should lick the spoon to get the proper dose.

Some of the vehicles by which disease is transmitted are: ocean liners, aeroplanes, baby carriages, and "ruff-on-rats."

An admission bath is given so that if there should be any foreign bodies in the hair they would come to light at once.

Puerperal infection is an infection acquired during child labor.

The causes of faulty posture are: (1) operations; (2) laziness; (3) dignity fails them.

Ophthalmia neonatorum is another name for night blindness.

The gluteus maximus is the muscle used in mastication

To prevent shock, choose a doctor who is noted for his efficiency and speed.

A pregnant woman should exercise only under the direct supervision of her doctor.

Prematurity means a baby born before the incubation period is over.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

An Experiment in Prenatal Education

MAUD (TISDALL) STAPLEY

IN THE FALL OF 1943, the need for prenatal education in nutrition was clearly demonstrated in Toronto by the findings of the Tisdall Ebbs Bell Report. Out of this need has evolved a unique experiment — the co-operation of six community agencies, combining their resources to provide free prenatal classes for all expectant mothers in Toronto and surrounding areas.

The original idea, conceived by the Visiting Homemakers' Association, was to start classes for prenatals to give instruction regarding diet and nutrition only. However, the value of a complete series, to include all aspects of prenatal hygiene, was soon apparent. A meeting was called in December, 1943, with the directors of the Department of Public Health Nursing, Victorian Order of Nurses, St. Elizabeth Visiting Nurses, and Visiting Homemakers present. As a result of their enthusiasm a series of twelve lectures in prenatal education was conducted jointly by a nutritionist and a nurse.

The first class was preceded by considerable publicity in the form of newspaper announcements and printed dodgers. It was quite well attended and very well received — so much so that the institution of a second class was indicated, and started the following February.

The success of these two experimental series confirmed the hopes of the original committee that they would be well received and attended. Their desire now was to expand, to have several classes conveniently located throughout the city, so that all expectant mothers might have the opportunity to attend easily.

The need to co-ordinate this scheme under a sponsor was felt. The health division of the Welfare Council, Department of the Community Chest of Greater Toronto, seemed the obvious answer. Under its leadership a meeting of all interested agencies was called, and broader, more long-term plans were drawn up. Experience gleaned from the two original series was carefully analyzed and all subsequent classes were modified from the trials and errors of these pioneer courses.

Since then the classes have enlarged and become more numerous, using more community agencies in their growth. Now eight weekly classes are in progress with an average attendance of twenty-five. Six agencies co-operate to conduct these prenatal courses — the original four

Mrs. Stapley, formerly with the Victorian Order of Nurses in Toronto, took part in the Committee on Prenatal Education of the Community Chest of Greater Toronto.

plus the Toronto Public Libraries and the Red Cross Society. The individual functions of each group will be discussed later.

The classes are administered under two committees — the Policy Committee and the Working Committee. The former deals with changes in policy, consent to open new classes, and delegation of the number of classes to be taught by each organization. The Working Committee is responsible for arrangement of classes, training of staff, time-tables, rearrangement and alteration of teaching material, and all matters to do with the detail of operation.

The classes are financed by the Community Chest and the participating agencies. The cost of operation is small as they are held in churches or club-rooms, the space being donated by these organizations. A small honorarium is paid to the janitor in each case, and a small sum is spent for refreshments. The greatest expense is the initial investment in equipment.

Publicity is a very important part of such a venture. Use of all available means is necessary — newspapers, radio, magazines, and pamphlets placed in hospitals, doctors' offices, stores where infant supplies are sold, etc. Letters are sent to all doctors with detailed information. This advertising must be a sustained campaign throughout the year. Our problem is not to keep the mothers coming to the classes, but rather to get them started. Another group to keep informed are the district public health nurses who are in contact with prenatals whom they can tell about the project.

At this point a word picture of how a class is actually conducted seems appropriate. The expectant mothers arrive at the door and are greeted by a Red Cross or other volunteer who marks their attendance. To any new member just starting, the worker explains the routine of a class and introduces her to other mothers. The nurse or nutritionist then conducts the lecture using charts and other teaching material suitable to the subject of the day. When the formal teaching is over there is a period for discussion. The volunteer serves light refreshments planned to be in keeping with the nutrition teaching. For example, a cream soup is served to illustrate a way to use milk on the day the importance and value of that food is taught. Tomato juice, another day, is served as an example of vitamin C.

During this informal period the nurse interviews any newcomers privately and has conferences with any members who wish a personal discussion. It is a period of sociability, and many mothers value the opportunity it has given them to make new friends. A layette and posters are on display during each class and this time affords leisure to examine them.

The present series consists of ten classes. An outline of teaching material has been drawn up, and the same lessons are given in all centres. The content has already been revised once to keep it abreast of new knowledge. It has been submitted to, and approved by, the departments of obstetrics, psychology, and pediatrics of the University of Toronto.

A course was conducted at the school of nursing of the University of Toronto to prepare teachers and potential teachers from the ranks of the Department of Public Health, Victorian Order of Nurses, St. Elizabeth Visiting Nurses, and Visiting Homemakers. These lectures discussed teaching methods, presentation of material, and teaching aids.

Each centre has its own equipment which makes the lessons more interesting and easily understood. This consists of a baby Chase doll, a baby's basket, made up with proper bedding, a layette which contains various acceptable types of diapers, shirts, etc., equipment for the bath, a baby's tray completely set up, a birth atlas, and various appropriate posters.

The first class is an introduction to the whole series and we try to have everyone who is going to participate present at this class. A member of the Community Chest Committee gives the background and introduc-

tion of the teachers of this particular series, and the volunteer welcomes new members. If possible, the librarian from the local branch public library comes to this initial meeting, bringing with her copies of books that are available on prenatal care, infant and child welfare, nutrition, recreation, and story books for children. She gives each member a book list and tells them how they can use the library facilities in their district. At this introductory class, the nurse discusses the need for medical supervision, and the nutritionist teaches the importance of homemaking and food in health and in pregnancy. The remaining nine classes are divided between the nurse and the nutritionist working together as a team.

The second class explains how the baby grows, and the onset and physiology of labor. The nurse finds the birth atlas, with its large clear illustrations, very helpful in teaching the subject. The third class is conducted by the nutritionist — her subject "Food Before the Baby Comes." In this she discusses the various factors in diet a mother needs to supply her baby with everything he requires for optimum growth. Then she relates these to everyday foods.

Classes four and five, taken by the nurse, deal with the hygiene of pregnancy — the expectant mother's physical and emotional reactions and adjustments, the value of good hygiene; danger signals; and recreation. The sixth class continues the discussion on nutrition, going on to meal-planning and buying.

The next two classes are the most popular of the series. Class seven deals with equipment for the baby, and class eight is a demonstration of bathing and dressing the baby — its principles and practice.

The ninth class is about food after the baby comes. It emphasizes breast feeding and the diet for lactation. It continues with early foods required by baby other than breast milk — the development of good food habits — and concludes with a discussion on economical and adequate selection of diet for the whole family.

Class ten deals mainly with child development — the first day home from hospital; routines and physical care; the father's part in baby's care; general hygiene; treatment of common causes of distress in infants; medical supervision of the well baby; immunization; normal development of the child. It also includes the value and importance of the post-natal examination for mothers.

The above material, suggested in the teaching manual for each class, is not necessarily all used. The teachers have to gauge the capacity and needs of their pupils, and modify their subject matter accordingly.

No organized courses such as these would be complete without some system of records. They are invaluable in analyzing past performance and as a guide to future development. Their fact-finding, unique of its kind, supplies pertinent research material. The forms are simple and are five in number. A form letter is filled in and sent to each new member's doctor, informing him that his patient is attending prenatal classes. An attendance record contains identifying information about each mother and the number of classes she attends.

A monthly schedule of classes is sent from each centre to the Welfare Council in advance, so that ready information is available when inquiries are made by the public. A report at the conclusion of a series is also sent. It is compiled from information taken off the attendance records and shows total attendance at each class, the number of admissions, the number of primiparas, the month of pregnancy when patients registered, by whom they were referred, and the number of women attending eight or more classes.

Six weeks after the expected date of confinement a questionnaire is mailed to each past member. These have been well returned and well filled in — not with just "yes" or "no" but with constructive suggestions. The questions deal with data regarding the actual birth, the baby's

condition, and the mother's condition. There is also plenty of space for comment and suggestions regarding publicity and improvement of subject matter of the course they followed. The latest revision of teaching material, which has just been completed, incorporated many of their ideas.

The enthusiastic answers to the first question "Do you feel you benefitted by these classes?" have more than made up for the early difficulties and disappointments which had to be overcome. They would be an inspiration to any community to start a similar project.

These prenatal classes have almost gone beyond the point of being an experiment. We feel they are an important and permanent force in the community working for, and helping to build healthy, happy parents and healthy, happy babies. It is hoped that an outline of the teaching material used in these classes will be available in this spring.

Venereal Disease Work in the Public Health Nursing Program

G. E. MacNeil

IN THE PUBLIC health program, venereal disease work has been, for the greater part, isolated from the other infectious diseases. This was done because the venereal disease program was new and it was felt that one worker would be sufficient until the work was organized. Once it was, the venereal disease work was to be taken over by the public health nurse and incorporated in the generalized public health program.

It is wise to have a nurse in this work rather than a lay person because the nurse, through her studies while in training and her experience with hospital patients, realizes the need for treatment far better than a lay person could. On the other hand, it is better if this nurse is a public health nurse for, with her varied types of calls, she affords the venereal disease patient a certain amount of protection that one person, known as doing venereal disease work alone, cannot give.

Some of the public health nurses have been doing venereal disease work, others have not. Many of them will find the thought of doing this work distasteful, and so it will be until the venereal disease program reaches the stage of organization that the other branches of public health have reached — for instance, the tuberculosis program. The reception of the tuberculosis field worker, when this work was begun, was anything but ideal. People for the greater part were ashamed of having the disease and resented greatly a visit from the nurse. We all know how changed that attitude is now.

The aim in venereal disease work, as with tuberculosis or diphtheria or any other communicable disease, is, of course, finding the source, tracing the contacts, and the examination and treatment of these people.

The attempt to carry this out will not always be satisfactory insofar as finding the contacts is concerned, as a source will often be found who is unable or unwilling to give the information sought. A feeling of frustration can easily result from a succession of such experiences, but when it is realized that here lies the opportunity of educating one person, at least, in regard to venereal disease; that this person, probably

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for the first time in his or her life, is made aware of the penalty to be paid for promiscuous behavior, aware of venereal disease, of its consequences without treatment and its curability, the feeling of failure should be lessened.

The people interviewed can be divided roughly into two classes: (a) the discharged service man or woman, and (b) the girl reported as a source of infection by a health department, a private doctor, or some other source.

The interviewing of the service discharges is made fairly simple by the fact that there is a service number through which the person may be identified without doubt. To add to this, the person is usually aware of the presence of the disease and has during his or her stay in the armed forces been educated in regard to venereal disease. Privacy is the main concern in speaking to these people. Naturally, curiosity will be aroused when a visit is made by the nurse who is known to be doing venereal disease work, and questions will be asked. The only way to deal with such a situation, since the patient has to be protected to the limit, is to treat it as though those who are questioning were prying into a personal affair.

With the girls reported as sources of infection, it is somewhat different. Not always is the information correct nor complete. These cases have to be handled with even more thought. Descriptions given are only rough ones and someone else's impressions. When a case arises about which there is doubt, it is best to delay the visit until further information can be obtained. This may be had from another department, a family doctor, or through casual inquiry without referring to the venereal disease.

At the interview, after the nurse has introduced herself, she tells her patient that someone, now being treated for venereal disease, named her as the source. Usually the girl will inquire for the person's name but this, being confidential, naturally cannot be given. This is a general opening and may be followed with the usual request that the patient report for examination and treatment. If names of contacts can be procured during this initial interview, this is the most opportune time.

Should the nurse be doubtful about a case, the approach may be varied slightly. The girl is told that someone, now under treatment for venereal disease, gave her name and, although she may not be the source, she may have contracted the disease. In the interest of her own health, she is asked to have the necessary examinations. This type of visit usually begets more co-operation than resentment.

The stubborn case will, of course, be encountered — the one who refuses quite actively or passively to be examined. For these cases there are venereal disease forms that can be signed by the health officer of the district and delivered by the police. These are usually effective.

It is hoped that the day will come when the public will be so well educated in health matters that these cases will be reduced to a minimum. Only then, will those people, who are now forced to take treatment, realize that they are not being singled out and made to take treatment as punishment for their misbehavior, but that actually they are fortunate in being made aware of the presence of disease and the availability of treatment for its cure.

Much depends upon our educational program. Although efforts have been made to reach the public, they are not yet ready to accept venereal disease as they do other communicable diseases. When they do, our venereal disease problem should not appear so formidable.

Finally, it would not be amiss to point out that although there are other phases of nursing more appealing and with more direct gratification, there is none that requires greater understanding of human failings and sympathy for those who accept this as the only way of life, generally because of financial and social handicaps. This is a vast new field of nursing and our country's social and health life depends on its success.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Les Vieux Cas de Syphilis

M. PAULE MCLEAN

Le Programme d'Etude à l'Usage du Canada dit à la page 53:

"Une fois l'élève entrée à l'école, elle se trouve dans un milieu où la maladie domine. Il est donc d'une importance primordiale que, dès le début, elle comprenne la relation qui existe entre l'hôpital et la santé publique et le rôle prédominant de l'infirmière du service social. A mesure qu'elle avancera dans les différents services, elle aura une connaissance plus approfondie du malade. Quels avantages l'élève retirerait si elle pouvait suivre le malade au dispensaire, au service social, et jusque dans sa famille."

Le travail de Mlle McLean démontre bien le rôle important de l'infirmière dans la société et que le malade à l'hôpital n'est qu'une partie du problème social qu'est la maladie.

Mlle McLean est au service du Ministère de la Santé provinciale à Chicoutimi, Québec.

J'AI CHOISI de vous parler, en tout premier lieu, de l'Assistance Sociale dans le dépistage des vieux cas de syphilis parce que je considère que ce sujet cadre bien avec le genre de travail qui m'occupe ordinairement. Dans une grande ville, comme Montréal ou Québec, où le va-et-vient est continuel et très intense, je comprends que le dépistage des infections récentes tienne la tête des activités antisyphilitiques. Chez-nous, les cas primaires ou secondaires sont plutôt rares. Aussi, le temps que je n'ai pas à dépenser pour la recherche des sources, des contacts et des délinquants est-il consacré au dépistage des vieux cas. Je surveille, bien entendu, mon "domaine" afin de ne pas me laisser surprendre par ce que je pourrais appeler: une épidémie de nouveaux cas de syphilis.

Je dois dire tout de suite que, compte tenu du travail abattu et des résultats obtenus chez le patient qui en est l'objet, le dépistage des anciens cas de syphilis n'est pas notre travail le plus encourageant. En effet, après avoir donné une partie du temps à l'organisation et à la pratique des prises de sang de routine, une autre partie à recueillir les informations nécessaires aux enquêtes, il arrive souvent que vous vous trouvez en face d'une personne d'un certain âge, (40 ans et plus), dont la maladie se résume à une réaction sanguine positive. Et c'est là que surgissent les difficultés. Une mentalité puritaine complique d'abord le travail. Puis c'est le danger toujours possible d'une tragédie familiale, même si vous réussissez une manoeuvre parfaite et que vous possédez un doigter incomparable, un doigter d'assistance sociale idéale. Et que de paroles, d'arguments pour convaincre le patient qu'il est atteint de syphilis et lui faire

voir et comprendre tous les malheurs qui peuvent fondre sur lui! Les difficultés ne sont pas moindres lorsqu'après avoir atteint ce but, on a réussi à le mettre sous traitement. Et le vieux cas, à mon avis, demande de la part du médecin, une compétence et des examens cliniques beaucoup plus poussés que le cas primaire ou secondaire. Maintenant, lorsqu'on a réussi à amener ce vieux cas au traitement, l'ennui, la gêne, la honte d'avoir à fréquenter le dispensaire ou le bureau d'un médecin, lequel en passant est souvent absent de son bureau, la crainte des injections ajoutée aux troubles qu'elles provoquent chez certains sujets, font que la plupart de ces gens suivent très mal leur traitement; le plus souvent, ils l'abandonnent avant la fin de la première année, surtout lorsqu'après deux ou trois séries bien suivies ils constatent que la positivité du sang sur laquelle on s'était basée pour faire leur diagnostic de syphilis est toujours là, irréductible. Les lettres et les visites suivent; le malade revient une fois, deux fois pour finalement ignorer poliment nos avis et nos arguments. Car, l'homme comprend par l'image, le concret. Les théories que nous lui présentons le laissent plutôt froid et sceptique. Etant donné son impérieuse aspiration vers le bonheur, il admet le malheur, mais pour les autres seulement. C'est là son attitude vis-à-vis des complications tardives qui pourtant peuvent le frapper un jour.

Et qu'avons-nous pour lutter contre cet état de choses? Rien que la patience et la persuasion. Du côté du malade, aucun malaise pour donner du poids à nos affirmations. La loi, de même, ne nous est plus d'aucun secours. Les responsabilités sociales, se bornant, éventuellement au seul domaine économique, ne peuvent être invoquées aussi efficacement. Quant aux responsabilités familiales, ou on les nie, ou on en diminue la portée, ou bien elles se détachent avec une telle netteté et d'une façon parfois si tragique que, souvent, la réaction normalement attendue vient en contradiction non seulement avec le point de vue médical, mais avec le patient lui-même, c'est-à-dire que ce dernier refuse de marcher dans le sens de la saine raison, le sentiment de sa propre sécurité étant le plus fort.

Ainsi, les efforts déployés pour réparer le mal déjà fait et prévenir d'autres maux éventuels restent vains. Chez la femme en particulier, l'amour propre vis-à-vis des grands garçons, surtout des grandes filles ira non seulement jusqu'à se protéger elle-même, mais jusqu'à vouloir sauvegarder le souvenir d'un père infortuné, qui a déjà payé de sa vie son écot à la syphilis. Pour les mêmes raison que celles citées plus haut, le médecin praticien n'aime pas lui non plus traiter les anciens cas. Il n'a rien de tangible à leur présenter; il ne peut leur promettre la guérison; tout se limite à des paroles d'encouragement. En outre, s'il est aisé pour un médecin d'accepter une rémunération pour avoir soulagé ou guéri un patient d'un mal douloureux, il n'en est pas de même lorsqu'il traite, et pendant des mois, un patient pour un mal qui n'a jamais donné aucun signe, aucune douleur, mal qu'il ne soigne qu'au cas de complications possibles, nécessairement toujours incertaines.

Je désire souligner un autre inconvénient (celui-ci, d'ordre local) qui provient du fait qu'il n'y a qu'un dispensaire situé à Chicoutimi. Il est assez facile d'y amener les patients d'Arvida qui ne sont qu'à 7 milles de notre ville, mais ceux de la Baie et des villes de Kénogami et Jonquière sont plus difficiles à diriger vers ce centre. Le trajet dans de vieux autobus, inconfortables, mal chauffés, dure de ¾ d'heure à une heure et coûte 80 cts, aller et retour, ce qui veut dire: $1.60 par semaine pour ceux qui ont deux traitements. Il s'ensuit un exode vers les bureaux privés. En passant, je note que ce sont les villes de Jonquière et Kénogami qui ont le plus haut pourcentage de cas dépistés par les prises de sang de routine. Même, les indigents iront chez leurs médecins, et celui-ci consentira rarement à les traiter gratuitement. Ceci ne veut pas dire que le patient paie toujours. Le plus souvent il ne paie pas, et, évidemment il n'est jamais victime d'un

recours légal, tout de même il éprouve un certain malaise du fait de cette contrainte morale qu'on se trouve à exercer ainsi sur lui et celle-ci, jointe à d'autres motifs, aboutit à l'abandon du traitement.

Nous avons, il est vrai, avec les industries une entente par laquelle tout employé trouvé syphilitique est gardé à son travail s'il suit son traitement, alors qu'il est mis à pied s'il ne le suit pas. Cette méthode, de prime abord très efficace, ne donne cependant pas les résultats qu'on aurait lieu d'attendre, car elle est assez difficile d'application et ce, dans la plupart des cas: ainsi les pères de familles qui sont à l'emploi d'une compagnie depuis longtemps, qui ont toujours bien fait leur travail, qui sont bien vus de leurs chefs, apparemment en bonne santé et auxquels le seul reproche qu'on peut adresser est celui de ne pas se soumettre au traitement. C'est certain que dans de tels cas, la raison ne réussit pas à faire taire des sentiments bien compréhensibles.

Maintenant, éloignons-nous du patient et considérons le dépistage des vieux cas en fonction de la lutte contre la syphilis héréditaire. L'aspect du travail présente alors plus d'intérêt. Les inconvénients cités plus haut nous accompagnent dans ce domaine comme dans le premier, mais, là, au moins, avons-nous un beau travail de prévention à faire. Nous avons aussi la loi pour nous appuyer s'il s'agit d'une femme enceinte et, surtout, le sentiment maternel que, j'oserais dire, chaque mouvement de l'enfant vient éveiller.

Bien qu'il faille tenir compte du pourcentage d'enfants qui naissent atteints de syphilis malgré que la mère ait reçu un traitement adéquat durant sa grossesse; ainsi que des infections insoupçonnées qui peuvent se présenter à partie du moment de la prise de sang jusqu'aux derniers mois de la grossesse. Bien qu'il faille aussi compter avec les cas qu'il nous est impossible de traiter, l'issue de la lutte que nous menons contre la syphilis héréditaire donne droit aux plus belles espérances.

Les prises de sang de routine nous permettent d'entrer dans les familles et de faire parfois un travail efficace. Si nous pouvons, en plus de cela, généraliser l'examen de sang pré-nuptial, et surtout amener les médecins à faire les examens de sang pré-natals, nous aurions à peu près gagné la partie. Je ne vous cache pas qu'une telle perspective me sourit beaucoup et tout en ne négligeant pas bien entendu, le vieux cas de syphilis dépisté par le système actuel de prises de sang, mon plus sincère désir reside dans l'atteinte des objectifs suivants. Premièrement: Maintenir le pourcentage des infections récentes à son taux le plus bas et en second lieu, abaisser le pourcentage de la syphilis héréditaire également à son taux le plus bas.

Maintenant, je vous dirai quelques mots de certaines catégories de patients. Je vous parlerai d'abord des bûcherons, non pas que cette classe de gens soit exclusive à notre région, mais plutôt parce que chez-nous elle englobe une plus forte partie de la population qu'ailleurs. Les hommes de chantiers, comme on les appelle au Saguenay, sont aussi nombreux que les travailleurs des usines. Seulement, si l'ouvrier de l'usine est un employé stable, celui du chantier ne l'est pas. Ainsi, Price Brothers, pour garder 10,000 hommes en permanence, a dû en embaucher 70,000. Ceci vous donne une idée du va-et-vient qui se fait dans ce groupe. Aussi le cas qu'on y dépiste ne se fait pas traiter, ou rarement, soit qu'il passe son temps dans le bois, ou que comme l'oiseau sur la branche il soit impossible à suivre. Un grand nombre de militaires ont dû prendre le chemin du bois à leur retour, et il se passe parfois des mois avant que je vienne en contact avec eux. S'il s'agit de cas d'infections récentes, la question est plus grave. Avant que ne soit institué le traitement rapide par la pénicilline, je faisais des démarches afin de placer ces gens à proximité de centres médicaux. Cà n'était pas toujours facile surtout dans la première année qui a suivi la fin de la guerre, alors qu'aux usines d'Arvida, au lieu d'embaucher les hommes, on les liquidait par centaines. Aujourd'hui cette question

est moins épineuse, grâce comme je le note plus haut, au traitement par la pénicilline. Là encore, la durée du traitement (1½ mois) soulève des complications. Le patient, lorsqu'il a passé 8 jours à l'hôpital est peu enclin à rester encore 5 à 6 semaines sans travailler et, malgré l'entente conclue, le traitement n'est pas toujours complété. Il faut croire que, selon l'avis du patient, le nombre d'injections qu'il a reçu durant ses 8 jours d'hospitalisation suffisent à sa guérison. Et c'est encore le chantier qui nous prend notre patient. Les sources et les contacts qui nous viennent du groupe de bûcherons sont très difficiles à atteindre, et non moins difficiles à raisonner, parce que peu ou pas instruits. Ils n'ont pas beaucoup le sens des responsabilités et lorsqu'ils nous renseignent sur leurs sources d'infections ou leurs contacts, ils le font plus par dépit que par esprit social. Lorsqu'il se trouve des bûcherons qui ne répondent pas aux lettres que je leur envoie, je fais appel aux bons offices du médecin de la Compagnie Price Brothers. Ce médecin fait le tour des camps environ une fois par mois, et il examine les cas que je lui soumets.

Petit à petit cependant notre dispensaire prend de la popularité auprès de cette classe de gens. Leur venue m'est très utile dans ce sens qu'elle me fournit l'occasion et le temps de faire leur éducation. Il se présente souvent des patients envoyés par des compagnons plus avisés. Quant à ceux qui nous connaissent déjà, ils viennent plus facilement nous consulter, lorsqu'ils ont quelque sujet d'inquiétude. En gonorrhée, il est cependant difficile de faire chez ces gens les examens de contrôle de traitement. Notre médecin croit qu'il ne faut pas s'alarmer outre mesure, car dit-il, s'ils ne reviennent pas, c'est qu'ils sont guéris.

Et je passe à une autre catégorie de patients, celle des marins. A venir jusqu'à l'automne dernier, cette classe de gens ne m'avait pas causé de graves soucis. Aussitôt le navire accosté à Port Alfred, tous les marins contaminés qui se trouvaient à son bord étaient envoyés à l'hôpital, le temps requis pour leur guérison, ce qui rendait impossible tout danger de contamination. Maintenant que le département de la marine ne paie plus pour ces cas, il survient des complications. Quelquefois le navire n'est qu'une journée, voir même quelques heures au port. Si ces heures et ces jours ne concordent pas avec ceux des cliniques, le marin doit s'adresser à un médecin privé, ce qu'il refuse parce qu'il n'a pas l'habitude de débourser pour ces sortes de maladies et, souvent aussi, parce qu'il n'a pas d'argent.

La plupart de ces marins sont des gas de gonorrhée sulfamido-résistants traités par le capitaine du navire. Ces marins se contaminent avant leur départ soit de l'Amérique Centrale, soit de l'Amérique du Sud; c'est ce qui ressort des enquêtes que j'ai faites l'an dernier. Celles-ci ont de plus révélé que la première escale de ces navires en Canada étant Port Alfred, il n'y a donc aucune histoire de contact au pays jusqu'à ce moment-là.

Quant à la prostitution dont les marins pourraient être l'occasion, j'ai demandé à plusieurs d'entre eux, déjà venus plusieurs fois dans la région, s'ils étaient sollicités par un grand nombre de filles. Tous m'ont répondu qu'ils n'avaient jamais réussi à attraper une fille. Je sais cependant que la guerre a contribué à rapprocher les gens de nationalité différente, que depuis ce temps, la "crainte" des marins a beaucoup diminué. Il s'en suit donc qu'une surveillance étroite doit être pratiquée de ce côté-là. Pour écarter le danger de contamination par les marins, lequel, je crois, est plus grand au point de vue syphilis qu'au point de vue gonorrhée, je compte obtenir les autorités du Port, qu'aucun marin suspect ou contaminé n'ait le droit de quitter son navire sauf pour venir au dispensaire.

En ce qui regarde le traitement des marins en dehors des heures des cliniques j'ai pensé que la Division pourrait peut-être me fournir la pénicilline nécessaire. Celle-ci serait administrée par l'infirmière du First Aid sous la direction du médecin du port.

(*La suite au prochain numéro*)

Nursing Profiles

Laura Beatrice Fair, A.R.R.C., has been named Supervisor of Nursing for the Ontario Hospitals under the Department of Health. For the year preceding this appointment, Miss Fair had served as executive secretary of the Manitoba Association of Registered Nurses. Miss Fair is a graduate of the Ontario Hospital at Whitby, completing her affiliation at the Toronto General Hospital in 1932. After five years as a ward supervisor, Miss Fair enrolled in the course in hospital administration and teaching in schools of nursing at the University of Toronto.

In 1938 she assumed duties as nurse instructor from which post she resigned in 1943 to join the R.C.A.M.C. She saw active service in Belgium and Holland, after a year in Great Britain. As president of the nurses' alumnae association of the Ontario Hospital at Whitby, Miss Fair kept in close touch with this type of work. Her new position gives her an opportunity to expand her sphere of influence.

Frances Ulva McQuarrie has been appointed Supervisor of Instruction at the University of Alberta School of Nursing. Graduating from the Vancouver General Hospital, Miss McQuarrie holds both her B.A. and B.A.Sc. from the University of British Columbia, majoring in teaching and supervision. In 1936 she accepted a position as head nurse at the Vancouver General Hospital going as clinical instructor to the Royal Columbian Hospital two years later. She returned to her home school in 1939 as science instructor. In 1944 Miss McQuarrie joined the nursing staff of UNRRA and assisted in the care of displaced persons in North Africa and Italy. Upon her return to Canada Miss McQuarrie organized a very successful course for nurses' aides in Vancouver. This varied experience ably qualifies her for the new work which she has undertaken.

Ashley & Crippen, Toronto

LAURA FAIR

Marjorie Jenkins, who since 1938 has been superintendent of the Children's Hospital in Halifax, has undertaken new duties as administrator of the out-patient department at the Victoria General Hospital, Halifax. A native of Ottawa, she graduated from the Hospital for Sick Children in Toronto, receiving her certificate in teaching and supervision from the McGill School for Graduate Nurses in 1925. She returned to the Hospital for Sick Children for two years as instructor becoming head nurse of the children's department at the Ottawa Civic Hospital in 1927. In 1935 Miss Jenkins was appointed superintendent of nurses at the Children's Memorial Hospital, Montreal.

Miss Jenkins served for three years as president of the Registered Nurses' Association of Nova Scotia and from 1942 to 1946 was honorary treasurer of the Canadian Nurses' Association. She served as chairman of the committee in charge of the Nurses' Official Directory in Halifax for five years. In addition to her professional activities she has also been active in a variety of well-known local organizations, including the Women's Canadian Club, the Mental Hygiene Society, and the United Nations Society.

Barbara Alice Beattie, who since 1941 has been superintendent of nurses at the Provincial Mental Hospital, Ponoka, Alta., has assumed the duties of superintendent of the Moncton Hospital, N.B. A native of Nova Scotia, Miss Beattie graduated from the Calgary General Hospital in 1921. After six years of private and general duty, she became nurse-in-charge of the Viking Muni-

cipal Hospital and three years later was named superintendent of the Drumheller Municipal Hospital. In 1939 she enrolled in the certificate course in school of nursing administration at the McGill School for Graduate Nurses.

Miss Beattie has always taken a very active part in nursing organization activities, having served on the executive of her hospital alumnae association and as first vice-president and president of the Alberta Association of Registered Nurses. Despite pressure of work, she was an active member of the Ponoka Golf Club and also the curling club. She is fond of skating, lawn bowling, horseback riding, and for indoor activity she specializes in amateur photography and photo-tinting.

Rice, Montreal

BARBARA BEATTIE

Margaret Augusta Evans has been appointed full-time assistant in the nursing office of the Department of Public Health, Alberta. Born in Edmonton, Miss Evans graduated from the University of Alberta, securing her B.Sc. degree in nursing in 1938. The final year of the latter course was taken at the Toronto University School of Nursing, specializing in teaching and supervision. For three years she served as instructor at the Moose Jaw General Hospital becoming the medical supervisor at the University of Alberta Hospital in 1941, succeeding to senior instructor there in 1943. She enlisted with the R.C.A.M.C. and saw service in Canadian military hospitals. On her discharge from the army she joined the public health service in Alberta and engaged in rural work prior to her present appointment.

Miss Evans has very divers sports interest, including skating, swimming, riding, etc. Among her accomplishments, photography and sketching also provide her with interesting pastimes.

Elizabeth Kenny McCann assumed her duties as clinical and field work consultant in the hospital field in association with the

Fowdry, Calgary

AUGUSTA EVANS

ELIZABETH MCCANN

DORIS WATSON

University of British Columbia last autumn. Graduating from the Vancouver General Hospital in 1939, Miss McCann holds her B.A. and B.A.Sc. from the University of British Columbia. She prepared herself for the work of handling students through special courses in job instruction training and job relations training. In 1945 Miss McCann took a post-graduate course in operating-room technique. Following graduation, she spent three years as nursing arts and clinical instructor at the Royal Columbian Hospital, New Westminster, joining the teaching staff of the Vancouver General Hospital in 1944. Perhaps it is in her activity outside of nursing that Miss McCann has secured greater experience in working with young people. Since

MYRTLE HODGINS

1931 she has been closely associated with Girl Guide work. At present she is captain of the Sea Ranger ship *Arethusa*. She spent her summer vacations for several years as nurse at the Guide camps until she received her own licence to conduct a camp. She is a member of the Alpha Delta Pi Sorority and active in music society work.

Cora Evelyn Droppo is superintendent of the General Hospital at Cobourg, Ont., succeeding **Janet A. Graham** who retired last autumn after faithfully serving for seventeen years. Born in Chesterville, Ont., with an English mother and French father, Miss Droppo graduated from the Cornwall General Hospital in 1928. After three years of private duty work she became supervisor at the Cornwall General Hospital in 1931, advancing to assistant superintendent in 1937. In 1941 she became assistant superintendent of the Galt (Ont.) Hospital assuming superintendency in 1944. For a year prior to her present appointment she was assistant superintendent at the General Hospital, Cobourg.

Miss Droppo has taken an active part in district work in Ontario, was a member of the Professional and Business Women's Club for a time, and spends much of her leisure knitting and reading.

Doris Janet Watson is the science instructor at Galt Hospital, Lethbridge, Alta. Graduating in 1938 from the Winnipeg General Hospital, Miss Watson spent three years in general staff work there before going to the Manhattan Eye, Ear, Nose and Throat Hospital in New York where she served as charge nurse. In 1942 she joined the staff of the Dauphin General Hospital, Man., as assistant superintendent. In 1943 she enlisted as a nursing sister in the Royal Canadian Air Force serving for two years. She recently completed a course in teaching and supervision in the school of nursing education at the University of Manitoba.

For leisure-time activities she turns to golf, skating, and bridge.

Florence Myrtle Hodgins has resigned after twenty years as operating-room supervisor at the Stratford General Hospital, Ont. Graduating from the Stratford General Hospital in 1924, Miss Hodgins served as night supervisor for a year, then accepted the post which she has capably filled for so long. At present her plans are indefinite, but

for a time at least she expects to "take a rest" at her home in Lucan, Ont.

Miss Hodgins is interested in music and collecting antiques, particularly old glass. We hope that during this period of rest she will have an opportunity for her hobbies.

In Memoriam

Mrs. Mary Bird, who served as a nurse with the Imperial Army during World War I, died last summer. Mrs. Bird was a member of the Regina Unit of the Nursing Sisters' Association.

Loretta Cleary, a graduate of St. Michael's (Toronto) School of Nursing, died on November 1, 1947, after a brief illness. After practising her profession in Toronto for some time, Miss Cleary went to the United States where she continued her work.

Eva Alvina (Jolliffe) Davies died in Rossland, B.C., on October 19, 1947, in her forty-fourth year. Mrs. Davies graduated from the Vancouver General Hospital in 1924.

Annie Frame, a native of Colchester County, N.S., died on October 12, 1947, after a long illness. Miss Frame taught for a number of years in the public schools of Nova Scotia. Later she entered a school of nursing in the United States and after graduation practised her profession for many years.

Mary (McKay) Heakes, who graduated from the Toronto General Hospital, died on November 1, 1947. Mrs. Heakes served as a nursing sister in World War I.

Helen Kendrick, who graduated from the Ottawa Civic Hospital in 1943, died on November 15, 1947, after a lengthy illness. Following graduation Miss Kendrick had been employed on the staff of the Civic Hospital until the time of her illness.

Margaret K. McCorkindale, formerly superintendent of the General and Marine Hospital, Goderich, Ont., died in October, 1947. A graduate of the Kitchener-Waterloo Hospital, Miss McCorkindale served in her profession in western Canada and in the United States for over thirty years. She had retired in 1941.

Imogene Pearson, who graduated from the Royal Victoria Hospital, Montreal, in 1916, died there last autumn after a lengthy illness.

Catherine F. Smith died in Victoria, B.C., on November 4, 1947, at the age of sixty-nine years. A native of London, England, Miss Smith nursed in the Bristol Infirmary whence she joined the Territorial Nursing Service in 1914. She received many decorations including mention in despatches, the citation for which read: "For gallant and distinguished service in the field."

Mary Ann Vance, who devoted more than half a century to nursing, including service through the first Great War with the R.C.A.M.C., died on November 15, 1947, at the age of seventy-five years. Miss Vance received her training at the former Western Hospital, Montreal, and at the Children's Memorial Hospital. Following her war service, Miss Vance was on the staff of Ste. Anne's Military Hospital for many years, later serving as matron of the Protestant Nursing Home in Montreal. She retired from active nursing two years ago.

Caroline Wellwood, who graduated from Sibly Memorial Hospital, Washington, D.C., died in Toronto in November, 1947. Miss Wellwood had the distinction of being the organizer of the first school of nursing in the province of Szechuan, China. She gave a lifetime service to the nursing profession in China serving for thirty-eight years under the auspices of the Women's Missionary Society of the United Church of Canada.

Pioneer Nursing

(*Continued from page 92*)

carrying away the things to the bathroom when she came up to see about it, I told her I had just done it. She seemed very much put out that I had the audacity to undertake such a big dressing. Then it was my turn to feel put out, believing as I did that I was only to expect to be shown once how to do anything. However, we always got on with each other very well, and she was always very good and kind in explaining things and would come up when she had a little time to spare and bring her little medical dictionary and give me words and meanings to learn, for I was very ignorant of everything.

I remained on night duty for five months. For more technical instruction we had to depend upon the doctors who explained symptoms and conditions to us and often let us use the stethoscope to listen to the heart or lungs. During the term when the medical students attended the bedside clinics, I would try to busy myself with a patient nearby or be ready to hand the doctor the chart. In that way I heard a good deal. On one occasion, I remember Dr. Good was lecturing about an operation he had performed on a patient's eye. He showed the students first of all how to take off the bandage, next how to roll it up on his knee, which he did standing. After changing the dressings he replaced the bandage, which was a double figure of eight over both eyes. I saw it from beginning to end and never forgot that lesson.

During the long stay on night duty, from July to December, much typhoid fever prevailed. Nearly every bed in the ward was occupied by typhoid patients besides the two private wards. Often there were several cases of pneumonia and phthisis in the same ward. The temperatures had to be taken every four hours and, if 103° or over, had to be sponged. The pneumonia patients had linseed jacket poultices, sometimes double, changed every four hours. The phthisical patients, after profuse perspiration, were bathed and rubbed with alcohol. All this had to be attended to by one pair of hands from 7 p.m. to 7 a.m. Woe betide the nurse if everything wasn't done and everything in place even to an eye-dropper or a medicine glass. Needless to say she did not have time to become drowsy but was quite ready for bed after breakfast. When the typhoid patients began to improve there would be a little lull in the work from 2 to 4, I passed the time going from bed to bed to take their pulses, and from that experience I learned a great deal as to the rate and character of the pulse.

The male medical ward contained twenty-four beds. The men's surgical ward of eight beds was at the extreme end of a long corridor. These wards were always full during the fall and winter. One nurse, with an orderly, looked after them. There were all kinds of dressings to be done from amputations to indolent ulcers, some requiring to be changed every four hours. They were all done in the wards by the nurse, which afforded great experience in bandaging. There was no surgical ward for women. They were placed in the women's medical ward even if it was breast amputation or abdominal operation. When I went to the hospital I made the eighth nurse. For day duty there were four graduate nurses — one in the isolated ward and one each in the surgical, men's medical, and women's medical, and two other nurses not trained. One graduate was the night supervisor. The hospital at that time would accommodate seventy-two patients. There was no provision for maternity work. Sometimes major operations were performed in the general wards. On one occasion when a resection of rib was done, Lister's carbolic spray was brought into use to purify the air. It fell to my lot to look after the spray to see that the proper proportion of carbolic and water were diffused. At that time no

operating gowns, aprons, or caps were in use. Real sponges, flat like a small plate, and small round ones were used. These were washed repeatedly, and used over and over again, in three basins of solution — carbolic, potassium permanganate and, finally, clear water. Nurses wore their ordinary ward dresses and aprons, not even removing cuffs.

I remember well a woman who was brought in for an ovarian operation. A special room was prepared, the walls and floor made as clean as possible, and shelves put up on which to place linen and utensils required for use. Everything was new directly from the store — mackintoshes, linen and blankets were supposed to be perfectly clean and pure. The patient remained in the room after the operation and the nurse also had a cot there and her meals were taken up to her. When the time came to examine the wound it was found to have healed by first intention to the very delight of everyone concerned, particularly the operator. It was understood at the time that it was the first abdominal operation to heal so perfectly!

In October, 1887, the training school was established, beginning with seven nurses taking a two years' course. Lectures were given at intervals, sometimes one a week, sometimes two, by the medical superintendent or a member of the visiting medical staff. Our instruction in anatomy consisted of two specimens — a femur and a rib. The rest we had to memorize from a very primitive book which was found in a second-hand book store along with one on physiology. Before the end of the second year of training we were supplied with a book on nursing written by Clara Weeks. We were given to understand it contained all that was necessary for us to know in regard to nursing. In due time the day arrived for our examination which began and ended in one afternoon. It was short but practical and even included an oral exam, which I remember to this day. The three older nurses graduated.

In the early days of our hospital life we students occupied rooms scattered all over the building, some in the basement and some in vacant private wards. One was in a good-sized closet with no window or ventilation except from the door. In 1888, a nurses' home was built and we had a sitting-room for our spare hours. A maternity cottage to hold seven patients was built and each nurse took her turn for the training. I was fortunate in getting three weeks and had five patients during the time. The nurse had to be over there at 6 a.m. to get her patients ready for their breakfasts and attend to the babies. Then she would go over to the home for her own breakfast, returning at 7 to get the patients' breakfast. The work continued throughout the day without relief until 11 and 12 p.m. It was in the days when the practice was for breasts to be massaged often. The work was arduous but great experience. Before the maternity cottage was built I was sent out to nurse a maternity patient in her own home. Needless to say I was almost terrified at the thought, never even having seen a case much less nursed one. However, the patient got along well and the grandmother was only too pleased and proud to attend to the baby. I never deprived her of the pleasure during my stay. I was sometimes very embarrassed by the awkward questions I had to answer or evade as I was supposed to know all about such things. The end of my stay in the maternity cottage closed my training days in the Winnipeg General Hospital on September 15, 1889.

In October, 1892, I was called to the Brandon General Hospital to take charge of several surgical cases that were to be operated on by Dr. A. H. Ferguson of Winnipeg. They occupied a room of five beds as the rest of the hospital was full of typhoid fever. By this time we had learned that boiling instruments and towels and using boiled water was necessary, also washing mackintoshes with some antiseptic. As there were no sterilizers for the purpose we used a large pot for the instruments and a steamer over it for

the towels. The boiling water was strained through gauze into large pitchers and an ample supply had to be on hand to cool. The gauze dressings were boiled, dried, then cut up and put into glass jars but not resterilized before use. There were several cases for abdominal operation, one amputation of leg, one who had a large cystic growth of the neck, one removal of tubercular glands, and several others of a minor character. We had three days of it — the first afternoon three cases, the next day six cases, and the next forenoon three more cases. The different doctors engaged in the work were very proud to know that all the patients recovered without suppuration except one who was operated on for a large abdominal abscess. In cleaning up and preparing for the next case each nurse was given her work and everything was done expeditiously with no confusion. All the nurses (6), including those for night duty (2), were present at all the operations. This meant that the day nurses remained on duty to allow the night nurses to get a little sleep. The beds for the patients were heated with glass bottles filled with hot water, covered with woollen socks, or large tin carbolic cans. We had no such luxury as rubber hot water bags or air cushions or Kelly pads. We had to improvise, making rings of cotton batting for the cushions and folding rubber sheeting for Kelly pads bolstered up with pillows. In the early years there was no water supply from the city but it was pumped up by a windmill into a tank in the attic. I remember on one occasion, the wind failed to blow enough to pump up the water. Consequently our supply ran short and we were reduced to such straits as steaming the linseed poultices over and over again instead of making fresh ones. Fomentation flannels were steamed too. The water for drinking purposes was hauled from town.

As there was only one orderly, a nurse must needs take the other end of the stretcher when taking a patient up or down stairs. In those days nurses were often sent out on private duty. This reduced the staff to a minimum but the work had to be done for all that, which made hours off duty almost nil. Maternity work was provided for in any single room that was vacant and night nurses were called to be present for the delivery. They then returned to bed. They were also called for all operations as it was their only opportunity of seeing them.

The nurses' home was built in 1904-5. At first, it only accommodated seven nurses, but before long had to be enlarged.

Typhoid season was always a very strenuous time, with so much sponging and bathing and very trying to a nurse on account of such low beds then in use. It was almost backbreaking at times. One time a private patient came in who insisted on having a special nurse. There was not one to spare from their ward work but the matron, Miss McVicar, who was never at a loss to meet emergencies, borrowed a uniform belonging to one of the nurses out on private duty, dressed a probationer who had only been in the hospital about ten days and presented her to the patient who seemed perfectly satisfied with her special nurse. The matron charged a fee of $10 per week for her services.

Dietary Deficiency Anemia

This condition occurs in cases where patients are on a milk diet for any length of time. It is apt to occur in infants who are continued on a milk diet for a longer period than normal or in premature infants where no excess reserve of iron was stored in the blood before birth; and in peptic ulcer patients on a milk and cream diet without supplemental iron . . . A daily dosage of 1 mg. of elemental copper to 25 mg. of elemental iron in milk for infants and small children is recommended. Larger doses are necessary for older children and adults.

Anemia rarely follows starvation due to the fact that the body conserves its reserves of iron when the supply is eliminated . . . Pernicious anemia is relatively rare in children under twelve, although states resembling this condition have been observed.

— *Medical Times*

Notes from National Office

Executive Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association is to be held at the Royal Alexandra Hotel, Winnipeg, March 18-20, 1948.

Registrars' Conference

For two days, immediately preceding the meeting of the Executive Committee, C.N.A., a most valuable conference was convened where the executive secretaries of seven of the provinces met with the general secretary of the Canadian Nurses' Association to discuss problems of mutual interest. Miss Lillian Grady, president of the R.N.A.N.S., represented her association. Present also, by invitation, were Miss Edith Dick, director, Nurse Registration Branch, Ontario; Sister Denise Lefebvre, honorary secretary, C.N.A.; Miss Eileen Flanagan, chairman of the national Committee on Constitution, By-Laws and Legislation; and Miss Margaret Kerr.

The recurrent problems associated with reciprocal registration between provinces received much attention. A resolution urging the implementation of a form of Dominion examination had been presented to the Executive Committee for consideration and, by it, was referred to the provincial associations for discussion. It was agreed that such an examination would have prestige value. However, since each provincial association would have to request its provincial legislature to amend the registered nurses' act to give legal standing to such examinations, it was decided to seek other means to facilitate reciprocal registration. The following recommendation was presented to the Executive and adopted:

WHEREAS the provincial association registrars in meeting assembled have carefully considered the implications of Dominion examinations, and

WHEREAS the consensus is that the time is not propitious for action,

Be it resolved, That plans or proposals for Dominion examinations be held in abeyance for the time being.

Discussion then focused on other aspects of this problem, such as the standardization of reciprocal registration application forms, the duplication of affiliation fees in returns to the C.N.A., etc. Differences in the educational requirements for registration emerged as one of the principal difficulties. Educational requirements are established in the various provincial acts, but a survey of them seemed to provide for greater latitude than is at present exercised in some instances. Accordingly, the following recommendation was framed and adopted by the executive:

WHEREAS there are differences in the educational requirements for registration from province to province which appear in some instances to hamper free reciprocal registration, therefore

Be it resolved, That the Canadian Nurses' Association recommend to the provincial nurses' associations that for the purpose of facilitating freer reciprocal registration of nurses, they adopt a more liberal and uniform interpretation of the academic requirements.

The simplification and standardization of the forms used by applicants for reciprocal registration was approved in the following recommendation:

Resolved, That the committee formed from the provincial registrars to study all the pro-

vincial application forms now in use for reciprocal registration be approved, and that they be asked to prepare a simplified form for submission to the provincial nurses' associations for their consideration, with a view to its adoption.

In an endeavor to promote simplification of registration for nurses emigrating to Canada and to avoid their disappointment when their qualifications fail to meet provincial requirements, the executive adopted the resolution that:

In view of the present problem of immigrant nurses, who arrive in Canada without having clarified the requirements for reciprocal registration in the various provinces,

Be it resolved, That the C.N.A. approach the Canadian immigration authorities with the request that when any of these nurses make application for immigration papers, the authorities impress upon them the importance of establishing eligibility for registration prior to emigrating.

The registrars also gave considerable thought to the matter of computing reliable statistics concerning the wastage rate of student nurses during training and means of assembling information regarding the incidence of illness among student nurses. Two recommendations were referred to the Executive Committee and adopted:

WHEREAS it is imperative that the wastage of student nurses be reduced to a minimum, and

WHEREAS there are well established psychometric tests available, therefore

Be it resolved, That provincial nurses' associations be asked to recommend the use of these tests in the selection of students for schools of nursing wherever trained personnel is available to give and interpret these tests.

WHEREAS it is imperative that the wastage of student nurses be reduced to a minimum, and

WHEREAS there is a probable proportion of students withdrawing from schools of nursing who might be retained in nursing, therefore

Be it resolved, That each provincial nurses' association be asked to assist the directors of schools of nursing by setting up a special committee to which these students could be referred for advice.

In considering the present shortage of nurses for general staff work in our hospitals, it was apparent to the conference that a broader basis for admission of students to our schools of nursing might assist in meeting the need. Many potential students, having normal school entrance or similar high school certificates, lack the university entrance qualifications which are essential for any graduate nurses wishing to pursue post-graduate study on the university level. It was, therefore, proposed that, where possible, the entering qualifications be broadened. The following recommendation was approved:

WHEREAS there is a continuing need for more bedside nurses as well as a need for university trained nurses, therefore

Be it resolved, That more liberal academic requirements for admission to schools of nursing be recommended to the provincial nurses' associations, and that a statement regarding her eligibility for entrance to university post-graduate nursing courses be given to each applicant to a school of nursing when her educational qualifications have been evaluated.

Summary of Reports

Many interesting reports were presented to the Executive Committee at the meetings held December 5-6, 1947. Space does not permit the publication of these reports in full. Some of the pertinent data have been selected for inclusion here for the information of the nurses of Canada:

On the basis of affiliation fees received from the provincial associations, the *Treasurer's Report* indicated that membership in the Canadian Nurses' Association was held by 22,700 nurses at September 30, 1947.

The need for a larger number of commercial advertisements to augment the revenues of the *Journal* was stressed in the report of *The Canadian Nurse*. It was recommended that the provincial registered nurses' associations set up special committees to canvass local possibilities. The payment of the regular commission on such advertising when published was authorized. The rates for professional advertising were studied and revised as follows: "positions vacant" or "positions wanted" advertisements: five dollars for three lines or less, one dollar for each additional line or

part line; Official Directory, five dollars for eight lines or less, fifty cents for each additional line.

The *Educational Policy Committee* reported that the details concerning the organization of the Metropolitan School of Nursing as the demonstration centre had occupied a great part of its time. The general plan for the operation of this school was described in the January, 1948, issue of the *Journal*.

The *Institutional Nursing Committee* has made a very comprehensive study of the various titles designating institutional positions for nurses. To promote effective placement, preparation, and functioning of personnel, and to avoid confusion in comparing administrative practices of different institutions, they have reached agreement on certain common titles for nurse positions and have defined each. This information will be made available in the April issue.

The *Private Duty Nursing Committee* reports a general decline in the number of nurses engaged in private duty nursing with an increased demand for their services. A study is being made of the possibility of establishing orientation programs to assist the private duty nurses who undertake general staff duty in the hospitals to adjust more readily.

The *Public Health Nursing Committee* pressed for implementation of the plan for the training of registered nurses in midwifery. This matter was referred to the Educational Policy Committee for study.

The *British Nurses Relief Fund Committee* reports the closing of this fund as a wartime measure. There is a balance of $1,037 and donations are still being received. Provincial and alumnae associations are continuing their interest in supplying the necessities of life to their colleagues in Britain as well as making donations of furnishings for the Rest-Breaks Homes. A new home is being planned for the north of England. These homes provide the opportunity for civilian nurses who were injured during war or whose health has been affected by it to rest for long or short periods as required.

The *Committee on Constitution, By-Laws and Legislation* indicated that the majority of the provincial associations had favored the policy of dual representation, that is, of a member holding an office on the executive of the Canadian Nurses' Association and of a provincial association at the same time. In the light of this provincial approval the executive endorsed the policy with the provision that the provinces so represented must respect their member's privilege of casting her vote as an individual C.N.A. officer. The regions from which members of the nursing sisterhoods are to be chosen for membership on the Executive Committee were defined as: Atlantic, Quebec, Ontario, the Prairies, and Pacific Regions.

The *Exchange of Nurses Committee* is working on the final draft of the legal contracts to govern exchange arrangements. Progress has been made in planning for insurance to cover risks which may be incurred, by exchange nurses. Currency exchange problems are the chief obstacle to the development of plans.

The *War Memorial Committee's* report indicated that 57.9 per cent of the original objective has thus far been obtained. The executive decided that the money-raising program should be extended to cover the entire biennium in order to permit as many provinces as possible to reach their objective. In view of the prohibitive cost of such classroom equipment as wall charts, Chase dolls, models, etc., and the problems of their transportation overseas, the committee was directed to continue to spend the money on the purchase of books for professional libraries.

Notes du Secrétariat de l'A.I.C.

Le Comité Exécutif

Le comité exécutif de l'Association des Infirmières du Canada tiendra sa prochaine assemblée du 18 au 20 mars à l'Hôtel Royal-Alexandra, Winnipeg.

La Conférence des Registraires

Deux jours avant la dernière réunion du comité exécutif de l'A.I.C., une conférence fut tenue par les registraires de sept provinces. Les registraires discutèrent avec la secrétaire générale des questions d'un intérêt commun aux provinces. Les personnes suivantes avaient été aussi invitées à assister à cette conférence: Mlle E. Dick, directrice du bureau d'enregistrement des infir-

mières d'Ontario; Soeur Denise Lefebvre, secrétaire honoraire de l'A.I.C.; Mlle E. Flanagan, convocatrice du comité national de législation et de règlements et statuts, et Mlle M. Kerr, éditeur du *Canadian Nurse*.

On porta une grande attention au droit de réciprocité entre chaque province, question qui soulève si fréquemment un problème.

La résolution demandant que l'on adopte une mode d'examens nationale a été présentée au comité exécutif pour étude et fut transmise aux associations provinciales pour discussion. Il fut décidé qu'un examen national donnerait un certain prestige. Cependant comme il serait nécessaire pour arriver à cette fin de demander aux législatures provinciales de modifier les lois des infirmières, afin de rendre légal un tel examen, il fut donc décidé de chercher d'autres moyens pour faciliter l'enregistrement entre les provinces.

La recommandation suivante fut présentée au comité exécutif:

Etant donné que les registraires des associations provinciales réunies en assemblée ont étudié avec soin la portée d'un examen national, et, étant donné que toutes sont d'avis que le temps n'est pas favorable à l'exécution d'un tel projet,

Il fut résolu, Que la proposition d'un projet d'examen national soit en suspens pour le temps présent.

La discussion porta sur divers angles de cette question de réciprocité, tel que l'uniformité des formules de demande d'enregistrement, la double contribution payée à l'A.I.C., etc. Les différents degrés d'instruction demandés par les provinces semblent être la grande difficulté dans l'enregistrement par réciprocité. Le degré d'instruction est déterminé par chacune des lois provinciales. En examinant ces lois on voit qu'elles sont moins régides qu'elles paraissent et laissent une latitude plus grande que celle que l'on admet actuellement. Alors la recommendation suivante fut préparée et adoptée par l'exécutif:

Etant donné que le différent degré d'instruction demandé par les provinces pour l'enregistrement semble empêcher les infirmières d'obtenir leur enregistrement par réciprocité, donc

Il fut résolu, Que l'A.I.C. recommande aux associations provinciales, qu'afin de faciliter aux infirmières l'enregistrement par réciprocité, que les associations provinciales interprètent avec plus de largeur de vue l'instruction exigée des candidates.

L'uniformité et la simplification des formules de demande fut approuvée et la recommandation suivante fut faite à ce sujet:

Il fut résolu, Que le comité nommé par les registraires provinciales, pour étudier toutes les formules provinciales de demande d'enregistrement actuellement en usage, soit approuvé et que l'on demande a ce comité de préparer une formule simplifiée, et de la présenter aux associations provinciales pour adoption.

Afin de faciliter l'enregistrement des infirmières émigrantes au Canada, et afin de leur éviter des désappointements, l'exécutif adopta la résolution suivante:

Comme il existe actuellement un problème, du fait que des infirmières émigrantes au Canada, sans s'être assurées des conditions requises pour obtenir l'enregistrement par réciprocité dans les diverses provinces,

Il fut résolu, Que l'A.I.C. voit les autorités du Département de l'Immigration du Canada et leur demande que lorsque des infirmières demanderont des formules pour immigrer au Canada, que les autorités insistent sur l'importance d'établir, en premier lieu, si elles sont éligibles à l'enregistrement.

Les registraires ont aussi délibéré sur les moyens d'obtenir des statistiques exacts sur la cause de départ des étudiantes infirmières et la perte de temps encourus durant les trois années de cours par maladie. Deux recommandations furent faites au comité exécutif à ce sujet:

Comme il est d'une grande importance que la perte de sujets comme élèves-infirmières soit réduite au minimum, et comme il y a des tests psychométriques à la disposition des élèves, donc

Il fut résolu, Que l'on demande aux associations provinciales de recommander l'usage de ces tests dans le choix des élèves infirmières, là où il y a une personne préparée pour donner et interpréter ces tests.

Comme il est de la plus grande importance que la perte d'élèves-infirmières dans nos écoles soit réduite au minimum et comme il y a probablement un certain nombre d'élèves se retirant des écoles qui pourraient demeurer dans la profession, donc

Il fut résolu, Que l'on demande à chaque association provinciale d'aider les directrices de nos écoles en nommant un comité qui pourrait être consulté par les étudiantes.

Considérant que l'on manque d'infirmières pour le service général dans nos hôpitaux, il appert à la conférence, qu'une interprétation plus généreuse du degré d'instruction

exigé des candidates à nos écoles soit un moyen d'aider à résoudre cette difficulté. Plusieurs candidates ont un diplôme d'écoles normes ou d'écoles primaires supérieures mais ne sont pas qualifiées pour entrer dans une université et poursuivre des études supérieures comme infirmières. Il fut alors proposé qu'une interprétation plus large soit faite des qualifications académiques. La recommandation suivante fut approuvée:

De même qu'il y a un besoin marqué pour un plus grand nombre d'infirmières auprès des malades, comme il y a un besoin d'infirmières ayant reçu une formation universitaire, donc

Il fut résolu, Que l'on recommande aux associations provinciales une interprétation plus large des qualifications académiques requises pour l'admission à nos écoles d'infirmières et après l'évaluation de son instruction qu'on remette à chaque élève admise une déclaration à cet effet.

Résumé des Rapports

Plusieurs rapports intéressants furent présentés au comité exécutif lors de l'assemblée du 5-6 décembre 1947. Les points les plus importants de ces rapports sont réunis ici:

Se basant sur les contributions reçues des provinces, *la trésorière* rapporte que les membres de l'A.I.C. étaient au nombre de 22,700 le 30 septembre 1947.

Du rapport du *Canadian Nurse* on voit que plus d'annonces commerciales sont nécessaires. Un comité devra être formé dans le but d'obtenir des annonces et une commission sera payée. Le taux pour les annonces professionnelles pour "positions offertes ou positions demandées" sera comme suit: cinq dollars les trois lignes — un dollar pour chaque ligne de surplus. Pour les listes officielles des différentes associations, le taux sera de cinq dollars les huit lignes et cinquante sous pour chaque ligne additionnelle.

Le *comité sur le programme éducationnel* donna des détails concernant l'organisation de l'école de démonstration "Metropolitan School of Nursing." Le comité a consacré tout son temps à ce projet. Les dispositions concernant cette école ont été données dans le numéro de janvier, 1948, du *Canadian Nurse*.

Le *comité du nursing des hôpitaux* a fait une étude sur les différents titres employés pour désigner les infirmières occupant des positions dans les hôpitaux. Le but de cette étude est de promouvoir un meilleur placement des infirmières, en faisant connaître la préparation nécessaire pour remplir une position déterminée, le travail et les responsabilités de cette position, et aussi afin d'éviter une confusion. Dans les différents hôpitaux on emploie pas toujours le même nom pour désigner la personne occupant la même position.

Le *comité du service privé* rapporte qu'il y a moins d'infirmières faisant de la pratique privée bien que leurs services soient de plus en plus en demande. Une étude est faite actuellement pour tracer un programme d'orientation, afin que les infirmières du service privé, faisant du service à l'hôpital, puissent s'adopter plus rapidement à ce nouveau milieu.

Le *comité d'hygiène publique* demande de mettre en oeuvre un plan pour préparation d'infirmières enregistrées à devenir sages-femmes. Cette question fut référée au comité de l'éducation pour étude.

Le *comité de secours aux infirmières de Grande-Bretagne* cessera d'exister. Il y a en banque une balance de $1,037 et on reçoit encore des dons. Les associations provinciales et les associations d'anciennes élèves montrent un grand intérêt envers les infirmières de Grande-Bretagne.

Le *comité de législation et de règlements et statuts* rapporte que la majorité des provinces sont en faveur d'une double représentation, ce qui veut dire qu'elle peut être à la fois sur le conseil de l'A.I.C. et sur le conseil provincial. A la suite de ce rapport des provinces, le comité exécutif adopte ce point de vue en autant que comme membre du conseil de l'A.I.C. la représentante soit libre de donner leur vote. Les régions d'où devront être élues les représentantes des communautés religieuses sont définies comme suit: Atlantique, Québec, Ontario, les Prairies, et le Pacifique.

Le *comité d'échange d'infirmières* est à terminer le contrat légal des déterminés, les arrangements à prendre dans ce cas. Un plan d'assurance protégeant les infirmières durant leur séjour au pays est en voie de réalisation. Les restrictions sur l'échange monétaire est la plus grande difficulté.

Le *comité de souvenir* rapporte que 57.9 pour cent de l'objectif a été atteint. La campagne de souscription se prolongera jusqu'au congrès biennal. La somme reçu servira à acheter des livres pour les infirmières des pays dévastés.

A bore is the kind of person who on being asked how he is, tells us.

Our Social Welfare Workers' Association

RUTH B. THOMSON

A Social Welfare Workers' Association?? Of what does it consist?—what is its purpose? — its aim — accomplishments??? Such were the questions that came to my mind when I joined the Child Welfare Nursing Service and became a member of the Social Welfare Association. Graduating just recently, I worked on the general duty staff of the General Hospital for several months. While in the hospital, we are not well acquainted with the social work done in the city — of which public health nursing is an integral part. Now, a child welfare nurse, I do see and appreciate the amount and type of work being done by the social organizations — thanks to my membership in the S.W.W.A. I was amazed to learn the number of different organizations represented — in all forty-five.

How did such an association come to be founded? In 1942, several of the social welfare workers met monthly to discuss the accomplishments and problems of interest to all. In November of that year, these workers decided to organize a social welfare workers' group which would be representative of all branches of social welfare work, the purpose of which would be to co-ordinate the work of all and to promote interest in social welfare. Thus, we have an active association holding monthly dinner meetings, membership being limited to those persons who are professionally engaged in community work.

These meetings have proven to be a great asset to the welfare work in Saint John. First, the members have become acquainted with one another and a more friendly atmosphere is created. Very often a case picked up by one organization has to be referred to another in order to have complete data. How much easier it is to discuss the matter with a person whom you know! It has also been found that greater things can be accomplished as one large association and that their recommendations are held in higher esteem than those coming from one individual organization. For example — during the year 1946 resolutions were unanimously approved by the association, calling for action to be taken as follows:

1. The revision of the Illegitimate Children's Act of 1927.
2. The revision of the N.B. Children's Protection Act of 1927.
3. Provision of suitable care and training of the mentally deficient.
4. Provision of a medical social worker at the provincial and general hospitals.
5. Extension of the Juvenile Court work to include the county.
6. Immediate erection of a health centre in the city.

The organization has some actual accomplishments, too, for example:

1. Certain recommendations were made and acted upon regarding a survey of the school attendance question.
2. Jail conditions for female prisoners have been improved.
3. A committee met with the municipal council to discuss conditions of a jail farm. Certain accomplishments resulted.
4. United action was taken on the question of pasteurized milk, and certain requirements resulted regarding this procedure.
5. The association sponsored a very successful social workers' conference for the city and county of Saint John.
6. The association also assisted to organize a Maritime conference which met last fall.

We well realize that "all work and no play" makes even professional workers dull people, so in May or June we all band together for a grand picnic in the country. The next day, our work does suffer somewhat, due to the strain of fighting black flies, not to mention the quantity of "hot-dogs," ice-cream and "pop" consumed.

Many wrongs have been righted in our city due to the presentations made by the Social Welfare Workers' Association. Those in authority realize the power which lies behind this one organization which represents forty-five.

Miss Thomson is a child welfare nurse with the Saint John Board of Health, N.B.

The most valuable result of all education is the ability to make yourself do the thing you have to do, when it ought to be done, and whether you like it or not. — *Huxley*

STUDENT NURSES PAGE

A Visit to the Leprosarium

JOAN R. AINSWORTH

LEPROSY, one of the oldest diseases recorded in history, is a chronic, infective, granulomatous disease, caused by a specific bacterium. The disease is characterized by lesions of skin, nerves, and viscera, producing a local anesthesia, ulceration, or some other form of lesion. In the middle ages it was widely distributed throughout Europe and Asia, but the disease is now almost entirely confined to tropical and sub-tropical regions. Any age group may be affected, but it most commonly occurs between the ages of ten and thirty. Climate is in no way a predisposing cause, but it has some influence in determining the type that the disease assumes; for example, the nodular form is more common in a cold, damp climate, the anesthetic form in warm or dry ones. Here in Bermuda, where the climate is sub-tropical, both types are found.

The causative agent is B. Leprae, an acid-fast bacillus, but the mode of transmission has been open to question. It is now generally conceded that contagion, i.e., direct contact from affected person to susceptible individual, is the only means of transmitting the disease, and then only following very intimate contact over a considerable period of time. The nodular type of the disease is potentially more infective than the anesthetic form.

Miss Ainsworth is a student nurse at the King Edward VII Memorial Hospital, Bermuda.

In its early stages, leprosy is not usually a characteristic disease, and is, therefore, difficult to diagnose. The incubation period is long, often over a period of years (on an average 7-10). The three main headings under which the disease may be described are:

1. Primary infection and incubation period, the disease remaining latent for a long time following initial infection.

2. The prodromal stage, characterized by pyrexia, often similar to malaria, dyspeptic troubles, general malaise, headache, vertigo, epistaxis, etc.

3. The appearance of a primary exantherma, a skin eruption varying considerably in size and pigmentation. A striking feature in this stage is the loss of hair in affected areas.

Following this eruption, a deposit stage is entered in which the tissue growths assume definite characteristics. The deposit occurs either in the skin or in the continuity of peripheral nerve trunks, or both. According to the site, nodular or anesthetic leprosy results. If both sites are involved both types of leprosy appear.

In Bermuda, fortunately, the number of lepers is small. At the present time, with one exception, the disease is confined to the colored race. The majority are of West Indian extraction, though Bermudian born. Provision for their care is made in the Island's Leprosarium, a self-sufficient colony, situated on a beautifully wooded hilltop along the south shore with a clear view of the south Atlantic

Oh, yes – you look sweet enough to kiss!

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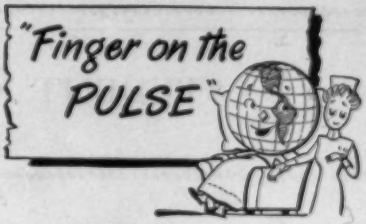

Power of Suggestion—A gala rain-making demonstration in the St. Louis' Parks Air College was postponed — on account of rain.

Back Again—After three tedious months, Alzar Arndt of Spokane, Wash., had the cast removed from his broken back. Out celebrating, somebody slapped him on the back and he found himself back in the hospital for further treatment on his back.

It Takes a Man—Frederick Newlings of Goulburn, New South Wales, was very proud of his feat when he was selected over eleven girls for the finals in a "lovely leg" contest.

Family Quarrel—It happened in Peiping, China, where one sister had her mother arrested as an opium smoker . . . the second sister accused their sister-in-law of adultery . . . the sister-in-law killed these two sisters and committed suicide. She left a note explaining that she had not murdered her husband because he, "unfortunately", was not at home.

"Do you think it's a flattering picture of me?"

Ocean. Recently, my fellow students and I were fortunate in being able to visit and inspect the Leprosarium, on the kind invitation of Dr. Hookings of the Department of Public Health. We certainly spent a most interesting morning, learning much about the disease and its treatment from Dr. Hookings.

The colony is built in a wide clearing and consists of a series of self-contained cottages, each arranged so that the occupant can from some window have an open view of the sea. Among the buildings are the surgery, open every morning when Dr. Hookings and a public health nurse visit, and a simple but beautiful little chapel. Immediately outside the enclosed compound is the caretaker's house. His wife does many services for the cottagers, if they are too ill or disabled to look after themselves.

On arrival that morning, we went first to see the surgery, where Dr. Hookings and his nurse were busy giving the daily injections of promin, a sulfonamide derivative. Promin is a water-soluble, white or yellowish-white solid that is indefinitely stable in a 40 per cent aqueous solution and may be sterilized by heat. It is unpleasant to take orally because it has a bitter taste and is, therefore, generally administered intravenously in doses of one to five grams daily for five or six days a week, over a period of two to three weeks, followed by a rest period of one week. The fact that promin proved so effective in bringing about resolution in tuberculosis suggested that the drug might be employed in the treatment of leprosy.

The report from the National Leprosarium, Carsville, La., has been so favorable that the drug is now being generally used in the treatment of the disease, having almost entirely superseded the chaulmugra oil treatment. Promin frequently renders the disease non-infective, therefore permitting release of patients during their periods of remission. Treatment with promin is necessarily long, often over a period of years, and the danger in its continual use is that a condition of leukopenia may result, which clears up spontaneously on discontinuance of the drug. Hence the rest period of one week every month during the administration of promin.

Leaving the surgery we visited each of the cottages in turn, staying for a few moments to talk with the occupants. These daily visits from Dr. Hookings are looked forward to eagerly and from strangers even more so, for these people, naturally, can have little contact with the outside world. Each cottage consisted of a bedroom, sitting-room, and kitchenette. All were very clean, being gaily decorated according to the owner's taste. A characteristic West Indian homemade wall-paper was particularly popular. It consisted of magazine pictures which entirely covered all wall space. Mrs. Trott's cottage contained pictures of every famous person today from "pin-up girls" to the British Royal family, Mr. Churchill, and Stalin. Mrs. Trott herself was suffering from the anesthetic type of the disease, and had lived in the colony for twenty years. By now several of her fingers have atrophied and she frequently burns herself when cooking, but she still prefers to do these things for herself. Her cottage and its little garden were very well kept. It is too soon as yet to report how promin has helped her, her treatment having only recently begun.

Following a tour of the cottages we came to the chapel in which the congregation is to this day separated from the priest, reminding us of Biblical times when no leper might enter a church. After this interesting but hot tour we came to the gate of the enclosure, where we noticed a watermelon patch cultivated by one of the inmates. Secure in our present-day knowledge of the modes of transmission and casting aside all thought of the old superstitions concerning leprosy, we were each very grateful to receive a large slice of delicious watermelon, before starting the bicycle ride home.

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Book Reviews

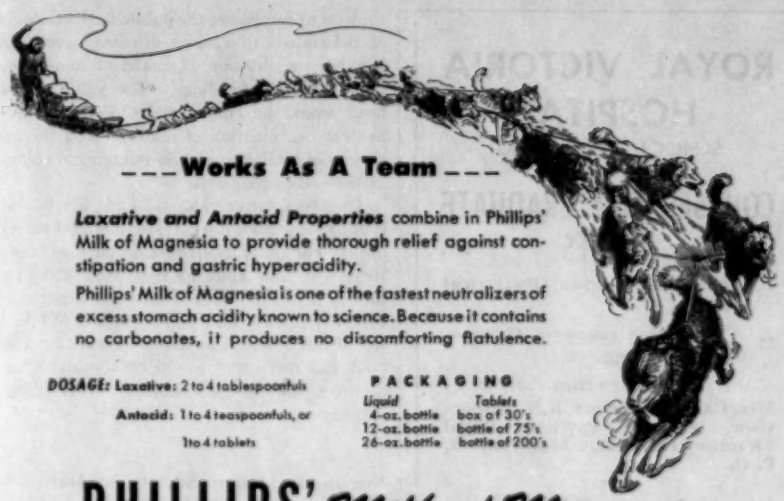
The History of the Victorian Order of Nurses for Canada, by John Murray Gibbon. 124 pages. Available from the Victorian Order of Nurses for Canada, 114 Wellington St., Ottawa, Ont. 1947. Illustrated. Price $2.00.

Fifty years of continuous service to Canadians is the proud record which is reflected in the pages of this history of the Victorian Order of Nurses for Canada. The rapid opening up of western Canada and the need of these settlers for medical and nursing care gave the impetus to the plan which Lady Aberdeen, wife of the Governor General, fostered and launched. The road was not easy, with strong opposition from unexpected quarters. One newspaper is reported to have stated at that time: "Only time is required to make the true nature of the Victorian Order of Nurses known, and then it will undoubtedly secure unanimous and hearty approval."

That this prophecy has been abundantly fulfilled is clearly revealed as the story of the growth and expansion of this service organization unfolds. The highlights from the early branch reports keep pace with the development of the various communities. The cottage hospitals seemed a logical first step, with the service expanding to the homes of those who were ill. During the influenza epidemic of 1918, the usefulness of a visiting nursing organization was demonstrated and proven. Financial problems confronted many branches following World War I and during the depression but public appreciation was so sincere and the opportunities for service so plentiful that the Order continued to expand.

Pen-portraits of notable persons who gave unstintingly of their support and endeavor make this a very human document. It is profusely illustrated which adds greatly to the interest. As a permanent record of a successful Canadian institution this small book merits a place in every school of nursing, hospital, and public health organization library.

Modern Methods of Feeding in Infancy and Childhood, by Donald Paterson, M.D. and J. Forest Smith, F.R.C.P. (London). 184 pages. Published by Constable & Co. Ltd., Eng. Canadian agents: Longmans, Green & Co., 215 Victoria St.,



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Toronto 1. 9th Ed. 1947. Illustrated. Price $2.50.

Reviewed by Marian Cochran, Head Nurse, Children's Memorial Hospital, Montreal.

In the ninth edition of this book we are given a clear, concise presentation of infant and child feeding, with nutritional requirements and values. The text, though small, is detailed and well illustrated.

The chapters on maternal feeding are particularly good, and include advantages to mother and child, contraindications, antenatal measures, diet of the nursing mother, and difficulties in breast feeding. Various forms of milk foods are described, including proprietary foods not in common use in this country.

Mixed feeding, which in this text means the addition of other foods, is not the same as is practised in Canada, but the fundamental principles are the same and the differences are mainly due to austerity conditions.

There are valuable chapters on feeding in diarrhea and vomiting, in wasting and in prematurity, and for sick children.

The appendices contain much useful information, including procedures for various techniques such as gastric lavage, expression of breast milk, etc., and tables of caloric and vitamin requirements and growth.

This book would be a valuable addition to the library of anyone interested in infant and child feeding and nutrition.

Infectious Diseases, with chapters on Venereal Diseases, by A. B. Christie, M.D. 324 pages. Published by Faber & Faber Ltd., 24 Russell Sq., London W.C. 1, Eng. 1946. Price 12s. 6d.

Reviewed by Pauline Capelle, Assistant Professor, Department of Nursing and Health, University of British Columbia.

The book "Infectious Diseases" is obviously the work of an authority. Facts are stated tersely and many involved concepts are simplified. At times this simplification goes to extremes and the content becomes attenuated to the point that pertinent material is omitted. To illustrate — under the heading of Food Poisoning no mention is made of botulism. In the same chapter, one questions the use of the terms Gaertner's and Aertrycke bacilli with reference to B. enteritides and B. typhimurium. The more modern classification is the Salmonella Group. Moreover, only four lines are devoted to this important group of organisms. An otherwise apt summary of syphilis is marred by the omission of routine prenatal blood-testing as a means of eradicating prenatal syphilis. Oppor-

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tunities to emphasize the public health aspects of the control of various diseases have been lost by the division of material under too many different headings. The value of the book would be enhanced by more comprehensive organization of material and the inclusion of bibliography and reference readings at the end of chapters.

On the positive side one finds a valuable synopsis of laboratory tests, comprehensive outlines of the various disease entities, their treatment and epidemiology, and thought-provoking chapters on the social aspects of venereal disease and tuberculosis. While I would not select it as a text, I feel that this book has merit and would be a valuable addition to the nurse's library as reference material.

Nursing in Modern Society, by Mary Ella Chayer, R.N., A.M. 288 pages. Published by G. P. Putnam's Sons, 2 West 45th St., New York City 19. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1947. Price $4.00.

With penetrating clarity, Miss Chayer has analyzed the problems confronting nursing at the present time — problems which exist both within and outside the profession itself. She has shown how the status of women has changed in the past decades. "Now that women are welcomed in most of the professions there is no longer available to teaching and nursing that large pool of women wanting employment." As a result of this and other factors greater reliance must be placed on those who are already members of the nursing profession. "With the increasing demand for nursing skills and the shortage of nurses nursing must modify its personnel policies to make the best use of the contributions of the older persons in the profession."

After discussing the various social forces affecting nursing, Miss Chayer indicates the ways in which nursing itself acts as a social force. The better utilization of nursing skills has brought recognition of a new type of auxiliary worker for both hospital and community work. Careful definition of functions is essential so that the public may be aware of the distinction between the various groups. "Once the functions of the auxiliary worker have been defined, the quality of performance of those functions should be as high for auxiliary workers as for the professional nurse."

"New proposals for extending and co-

ordinating hospital and public health facilities are going forward, forcing the attention of nurses toward new patterns of community service." How these new demands will alter the present pattern of the education of nurses is carefully considered. The second part of the book outlines the influence of social forces upon the community health needs. The last three chapters point the way to "a better future."

Thought-stimulating questions are appended to each chapter. The references are clearly marked with a comprehensive bibliography at the end. The detailed index will make it very easy for nurses to find information which they will welcome when called upon to discuss present-day trends in nursing. Every nurse who is alive to the current problems will benefit from an opportunity to study and ponder the information available here.

Course of Lectures, 1891-92

The course of lectures delivered by the medical and surgical staff at the Prince Edward Island Hospital during 1891-92 was as follows:

General and regional anatomy — four lectures.

Circulation, pulse, respiration, temperature, secretions, excretions, examination of urine, digestion, the preparation and methods of serving various foods, etc. — four lectures.

The sick room: Ventilation, temperature, disinfectants and deodorizers, contagious diseases; inflammation, suppuration, septicemia, pyemia and gangrene, etc., principles of antiseptic surgery — four lectures.

Toxicology, common remedies, their doses and methods of administration — two lectures.

Administration of anesthetics, care of patients during and after operations with possible emergencies, (shock, hemorrhage and collapse) — two lectures.

Surgical dressings, fractures, dislocations and their treatment, application of splints, bandages, etc. — four lectures.

Diseases of the eye, ear and throat — two lectures.

Mental and nervous diseases—two lectures.

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Nursing Sisters' Association

The *Vancouver Unit* has completed an active and interesting year — four general and eight executive meetings being held. Many nursing sisters of World War II have joined the unit, bringing with them much youthful enthusiasm. There are 125 paid-up members although at the social functions this number is greatly enlarged.

There was a good attendance at the 1947 annual meeting when a movie was shown depicting some of the work being done at the Shaughnessy Hospital. Dr. Starr was the narrator. Later, tea was served and the members taken on a tour of the hospital. A bridge and rummage sale proved profitable and a tea at Hycroft Hospital, when the patients were guests, was much enjoyed. A wonderful time was reported by all who were present at the picnic held at the home of Mrs. Shepherd and Miss Conway Jones on Lulu Island. The street-car strike caused the cancellation of the Armistice banquet but many sisters attended the services and a poppy wreath was placed on the cenotaph by the president. A successful bazaar was held at the New Veterans Hall. This activity entailed a great deal of work on the part of those who assisted in making this venture worthwhile.

Apart from social activities, members have made supplies for the blood donor clinics and packed 60 pounds of uniforms which were sent to Europe. Socks are made regularly for the Shaughnessy and Hycroft patients. A contribution of $116 was raised for the War Memorial Fund and $25 donated to the Laura Holland Scholarship Fund.

A portrait of the late Jean Matheson was presented to Shaughnessy Hospital and hung in the Jean Matheson Pavilion dedicated to the memory of their first matron, the late Jean Matheson.

Alberta

The following are recent staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Angela McIntosh* (Ontario Hospital, Brockville), of Long Branch, Ont., to Hilda; *Lillian Tweedie* (Misericordia Hospital, Edmonton), of Sedgwick, Alta., to Wainwright; *Dorothy (Colgan) Brickett* part-time at Maloy; *Almeda (Hincks) Kristensen*

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(Grace Hospital, Toronto, and University of Toronto public health course) part-time at Dixonville.

Leaves of Absence: *Wilma McCordick*, of Rocky Mountain House, to visit Ireland.

Transfers: *Mrs. Margaret Faulkner* from Newbrook to Peers.

Resignations: *Mrs. Alice Murphy*, at Breynat since 1940, to visit Texas; *Marjorie Maynes*, on leave of absence from Smith, to join Child Welfare Clinic, Calgary; *Betty Lea* to join Child Welfare Clinic, Edmonton, as permanent staff member; *Helen Head* from Dixonville to "special" in Edmonton.

Marguerite Weder and *Lillian White* have rejoined the staff after four-month leave of absence to take the course in advanced obstetrics.

Dr. Enid (Newland) Tredger, a graduate in medicine from the University of Alberta, and *Ruth (Gilchrist) Stevens* (University of Alberta School of Nursing) have launched monthly well baby clinics in High Prairie and Girouxville as a basic service in the High Prairie health district which at present is not operating.

Income Tax Deductions

Private duty nurses have more responsibility in the matter of filing income tax returns than other groups of nurses whose tax is deducted at the source. It may be pertinent at this time, therefore, to present a few pointers which may be helpful.

Private duty nurses are required to file a quarterly statement on their estimated income for each period and an annual statement of their actual earnings. This income includes not only the total amount received *per diem* but also the sums received in payment for their meals.

Deductions are permitted on a wider range of items than nurses in other branches of nursing enjoy. For each deduction claimed,

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official receipts must be provided. Deductions are allowable for: provincial and registry fees; laundry; professional magazines, including *The Canadian Nurse*; instruments which are necessary in her work; and, of course, charitable donations. If no receipts are at hand for the laundering of uniforms, fifteen cents for each day worked may be deducted. No deductions are permitted for the purchase price of uniforms, shoes, etc.

Nurses' Salaries in N.Z.

The New Zealand Registered Nurses' Association, in the October, 1947, issue of their official *Nursing Journal*, reports the formation of a governmental body known as the Hospital Board Nurses' Salaries Advisory Committee. The association had approached the Minister of Health in 1945 asking that consideration be given to the possibility of setting up some type of Salary Board representative of all nurse employer and employee interests, which could exercise the power of determining minimum and maximum salaries to be paid to nurses. The first meeting of the new committee was held last September. The Minister of Health has recognized the N.Z.R.N.A. "as being constituted to promote or safeguard the interests of nurses employed by hospital boards."

"It has been recommended by the executive to all branches of the association that committees, whose function is to deal with all anomalies of salaries and working conditions of nurses, be set up within each branch, and recommendations forwarded through these committees to the executive of the association, which will co-ordinate all recommendations before submitting them to the Salaries Advisory Committee. In this way, all grades of nurses and nurses in all types of work will have a voice in preparing recommendations, and the whole responsibility will not be left to the central executive as has been in the past. Although the Advisory Committee will deal with hospital nurses in particular, any decision arrived at will indirectly affect all classes of nurses, and for this reason it is recommended that local committees be representative of nurses in all avenues of employment."

The Physiological Effects of Wounds

New principles in the treatment of the severely wounded, based on a review of more than 1,600 cases from the Cassino and Anzio battles early in 1944, were described in a special study made of care of the wounded from the time of the injury until the patient

was in the hands of a surgeon. One curious finding was that in the majority of cases severely wounded men do not suffer severe pain. Three-fourths of those who arrived at the most forward hospital, even though they had had no morphine for five hours or more, said they were not suffering enough to want anything done about it.

On the other hand, those in a state of shock due to blood loss nearly always complained of severe thirst, presumably due to the fact that water had been drawn from the tissues to replenish the fluid in the circulation. This is the explanation, it is believed, of the plea for "water" so often heard on battlefields throughout history. This state is the most serious type of shock encountered. It was treated wherever possible with blood plasma in copious amounts. But in the men wounded in the Italian battles it was found the plasma was much less depleted than the red blood cells, so much so that there must be some unknown reservoir of proteins in the body which is drawn upon in case of emergency.

The plasma treatment is of great value to tide over the period until a whole blood transfusion can be made. Shock could be cured only by whole blood. It was found essential to administer whole blood even when the soldier was on the operating-table. It was shown that the quantity of blood and plasma needed for resuscitation can be reduced to about one-half that called for by older and slower methods. At the same time delay in undertaking surgery because of shock can be cut about two-thirds by whole blood transfusions while the surgeon is at work.

— *News Notes No. 62.*

Children's Vision Studied

A study of the methods of testing the vision of school children is being planned by the National Society for the Prevention of Blindness and the U.S. Children's Bureau.

What methods of vision testing should be used in school health programs, who should carry out the tests, and what findings as a result of these tests should be considered an indication for referring the child to a physician for a complete examination are a few of the questions the study will attempt to answer.

The plan grew out of a meeting of many agencies interested in the health of children which was held last summer in Washington, D.C.

A recent survey shows that during 1945 one patient was admitted to a hospital in the United States every 1.9 seconds. And a live baby was born in a hospital every 16 seconds.

— *Oklahoma Health Bulletin*

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1. **Degree Course in Nursing:** A five-year course leading to the degree, Bachelor of Science in Nursing. Opportunity is provided in the final year for specialization.

2. **Diploma Course in Nursing:** A three-year course leading to a Diploma in Nursing.

Post-Graduate

1. **One-Year Diploma Courses:**
   (a) Teaching and Supervision in Schools of Nursing
   (b) Public Health Nursing

2. Four-month certificate course in **Advanced Practical Obstetrics.**

For information apply to:

The Director,
School of Nursing, University of Alberta
Edmonton, Alberta

News Notes

ALBERTA

CALGARY:

The annual meeting of the Calgary General Hospital Alumnae Association was held recently, when Marion Moodie, the first nurse to graduate from the hospital, was made an honorary life member to commemorate the Golden Anniversary of the training school to be held this year. Mrs. B. M. Porter will convene the graduation banquet and plans were discussed for the celebration of the anniversary. The alumnae will sponsor the first two nights of the Ice Follies on April 29 and 30. Mrs. T. L. O'Keefe will serve again on the hospital board this year.

The new executive was installed with the result that the president is now Mrs. A. E. Wilson with Mrs. W. H. B. Kirkpatrick serving as first vice-president. The recording secretary is M. O. Harback and Ernestine Peel will act as corresponding secretary. The treasurer is Mrs. C. B. Thompson.

Mrs. B. C. White and her committee served refreshments.

BRITISH COLUMBIA

KAMLOOPS-TRANQUILLE:

Dr. I. Smillie gave a very interesting talk on "The Various Aspects of Public Health" at a meeting of Kamloops-Tranquille Chapter, R.N.A.B.C.

The December meeting took the form of a Christmas social when ten dollars was voted in aid of the Princess Elizabeth Food Fund. Letters were read from Olive Garrood, a former member, who is in Australia, and from L. Sandale, who is reorganizing her work in Korea. It was decided to use the remainder of the raffle fund for parcels to British nurses and Miss Sandale. A radio is to be procured for the hospital room in the new wing furnished by the nurses.

TRAIL:

At a recent meeting of Trail Chapter, R.N.A.B.C., an instructive lecture on "Shock Therapy" was given by Dr. J. S. Daly. Ten dollars was voted towards the Princess Elizabeth Fund for parcels to Britain.

VANCOUVER:

St. Paul's Hospital:

The first alumnae meeting of 1948 was held on January 6 in the nurses' home. The agenda for the coming year was discussed. Prominent on the calendar for the early months of this year are the home-coming and the annual spring dance. The January class of 1942 held a reunion on the evening of January 7.

Vancouver General Hospital:

The nurses of the V.G.H. are remembering their sisters in Great Britain. Last summer they packed and shipped four hundred pounds of good clothing, including suits, overcoats,

sweaters, berets, underclothing, shoes, nursing uniforms.

Collections for food parcels for British nurses at present amount to more than $500 and food parcels are being sent monthly to Frances Goodall, general secretary of the Royal College of Nursing.

MANITOBA

BRANDON:

Marion Patterson, the president of the Brandon Association of Graduate Nurses, was in the chair at a recent meeting when Isobel Lamont's group took charge. The guest speaker was Jenny Gemmell who gave an interesting talk on "Chinaware" using various pieces to illustrate her address. Mrs. M. McNee introduced Miss Gemmell who was thanked on behalf of the members by Mrs. E. Hannah. A social hour followed.

NEW BRUNSWICK

SAINT JOHN:

Grace Williams has resigned from the V.O.N. staff to do general duty at the Presbyterian Hospital, New York. Elizabeth Barry and Beth Boulter have resigned from the Child Welfare staff — the former to join the V.C.N. and the latter to take a position with the Ontario Society for Crippled Chidren.

General Hospital:

At a meeting of the alumnae association, when Bea Selfridge presided, Dr. K. A. Baird addressed the meeting, his topic being "The Human Thumb." Mrs. Mooney also gave an excellent report on her visit to the I.C.N.

The annual Christmas dance, held by the student body, was a great success, and the Christmas party, which included both staff and students, was also much enjoyed by all who attended.

Mrs. Ball (Hazel Tracey) has resigned from the children's division and will reside at Fredericton Junction. Mrs. E. T. K. Mooney has been named nurse in charge of the cancer clinic. Isabelle Richardson has accepted a position in Dr. Jos. Tanzman's office. Frances Howard is taking a post-graduate course at the Boston Lying-In Hospital. Mary MacDougall has sailed from Portugal and is now in Chissamba, Angola, Africa.

ONTARIO

DISTRICT 5

At an executive meeting plans were made to hold the annual meeting and banquet of District 5, R.N.A.O., at the Royal York Hotel, Toronto, on February 23. The speaker at the banquet will be Charlotte Whitton. The resignation of the secretary-treasurer, Ethel Greenwood, was received and plans were made to advertise the position.

TORONTO:

The alumnae association of the Grant Macdonald Training School, Queen Elizabeth Hospital, gave a tea to raise funds for the War Memorial Fund, when thirty dollars was realized.

Good As Gold

What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

BABY'S OWN TABLETS

LAW AND THE PRACTICE OF NURSING

By Nettie D. Fidler, B.A., R.N., in collaboration with Kenneth G. Gray, M.D., K.C. In this authoritative book the authors discuss both the legal privileges and legal responsibilities of the nurse. They explain how her status varies from province to province in Canada. Chapters include: Legal Principles; The Patient, the Doctor and the Nurse; The Hospital; Drug Control; Mental Illness; Public Health; Health Insurance; The Organized Nursing Profession; Nursing Legislation.

To safeguard her position, every practising nurse should be familiar with the information in this book. A copy would prove invaluable for reference in every medical and nursing library. $2.00.

THE RYERSON PRESS
TORONTO

THAT ALL UNIFORMS CLOTHING AND OTHER BELONGINGS ARE MARKED WITH

CASH'S Loomwoven NAMES

Permanent, easy identification. Easily sewn on, or attached with No-So Cement. From dealers or CASH'S, 38 Grier St., Belleville, Ont.

CASH'S: 3 Doz. $1.65; 9 Doz. $2.75; NO-SO NAMES: 6 Doz. $2.20; 12 Doz. $3.30; 25c per tube

REGISTERED NURSES' ASSOC'N. OF BRITISH COLUMBIA
Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director Placement Service
1001 Vancouver Block, Vancouver B.C.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA
(Incorporated)

An examination for the title and certificate of Registered Nurse of British Columbia will be held on March 16, 17 and 18, 1948.

Names of Candidates for this examination must be in the office of the Registrar not later than February 16, 1948.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar, 1014 Vancouver Block, Vancouver, B.C.

Head Colds

CHECK SNIFFLING

Mentholatum quickly relieves head colds; checks sniffling; soothes irritated membranes. Jars and tubes, 30c.

V-2

MENTHOLATUM
Gives COMFORT *Daily*

SASKATCHEWAN

HUMBOLDT:

Rosella Breker is now on the staff of the operating-room at St. Elizabeth's Hospital. Miss Breker also replaces Mrs. Grace D. Chamney as secretary of Humboldt Chapter, S.R.N.A. Mrs. Chamney is now in Watrous.

MOOSE JAW:

The Regional Health Office has two new members on its staff — Jean McIntyre and Mary Cutts — while Mrs. Harry Jones has resigned.

General Hospital:

Doris Anderson has resigned from the Kelowna General Hospital. Edna Boychook has resigned from the surgical department and has left for California to take a post-graduate course in surgery.

SASKATOON:

City Hospital:

A tea was held by the staff in honor of Mr. L. Goudy, superintendent of the hospital, who resigned to accept a position with the American Hospital Association. Mr. Goudy was presented with a travelling bag as a parting gift. Mr. A. Esson is the new superintendent.

St. Paul's Hospital:

The school of nursing library has been enriched by a donation of fifty books, the gift of Mr. Felix J. Lafferty, a St. Paul's graduate, who is now studying medicine. Sr. D. Lefebvre, director of the Institut Marguerite d'Youville, Montreal, gave a short course on psychology and clinical teaching to the graduates during her visit to the hospital.

The graduate nurses presented Mrs. Fay (Lawley) Giles, a recent bride, with a lovely blanket. Fern Burger, after completing a course in pediatrics in Montreal, is now on the staff of the Children's Hospital there. D. Moore, K. Coflin, and L. Frey are taking a course in obstetrics at the Royal Victoria Hospital, Montreal.

SWIFT CURRENT:

At a meeting of Swift Current Chapter, S.R.N.A., an interesting talk was given by Mrs. Torrens, who has recently arrived from England. She compared nursing in Canada and Britain. In December the nurses were entertained at a party given by the hospital board and staff and the Ladies' Aid. Olive Senum and C. Flynn are now on the staff of the General Hospital.

WEYBURN:

Ann Shave has joined the General Hospital staff.

YORKTON:

Mrs. K. McRae, president of Yorkton Chapter, S.R.N.A., has left for Indian Head, much to the regret of the chapter members.

Positions Vacant

Superintendent, fully qualified, to take complete charge of a 24-bed General Hospital. Apply, stating qualifications, age, references, and salary expected, to Mr. A. M. Casselman, Sec., Haldimand War Memorial Hospital, Dunnville, Ont.

Superintendent of Nurses for 115-bed (approx.) hospital. To be completely responsible for nursing services and allied departments and for School of Nursing of approx. 30 pupils. (School has instructor.) Salary with full maintenance: Approx. $2,800 per annum, more or less, according to qualifications. Apply in care of Box 2, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Obstetrical Supervisor, with post-graduate experience, for busy 20-bed Maternity Dept. Apply, stating qualifications, salary, etc., to Supt. of Nurses, General Hospital, Yorkton, Sask.

Nurse, with some **Public Health** experience, for attractive opening with Athabasca School Division No. 42. The One Nurse Health Unit is operated jointly with the Dept. of Health. Late model car and adequate office premises provided. Salary as per schedule. Apply to J. A. Macintyre, Secretary, Colinton, Alta.

General Staff Nurses (5) immediately for 35-bed General Hospital (surgery, medical, obstetrics). Salary: $135 gross, less $25.00 for maintenance, laundry. Straight 8-hour shift and 6-day week; statutory holidays. 2 weeks' sick leave annually with pay granted. 4 weeks' vacation after 1 year of service. Nurses' residence, which is separate from hospital, provides single rooms and comfortable living room with fireplace and radio. District around noted for its beautiful scenery. Here is an opportunity to come out West and see the West in all its splendor. Apply immediately to Miss D. Berhendt, Supt., General Hospital, Ladysmith, Van. Is., B.C.

General Duty Nurses for medium-sized General Hospital in Niagara Peninsula. Good working conditions (48-hour week), and attractive salary plus full maintenance. Apply to Supt. of Nurses, County General Hospital, Welland, Ont.

Registered Nurse immediately for newly-equipped 10-bed hospital in Saskatchewan. Resident doctor. State salary expected. Wire or phone collect or write to S. Smith, Pres., Bracken Hospital Board, Bracken, Sask.

Superintendent of Nurses for 16-bed modern Municipal Hospital at Eckville, Alberta. Duties to commence immediately if possible. For further information write to Sec.-Treas., Municipal Hospital No. 30, Eckville, Alta.

Graduate Nurses (2) for General Duty in a modern 16-bed hospital, very busy centre, at Eckville, Alberta. For further particulars write or wire collect to Sec.-Treas., Municipal Hospital No. 30, Eckville, Alberta.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, P.Q.

Matron. Salary: $150 per month plus maintenance. **Graduate Nurses (2).** Salary: $120 per month plus maintenance. 16-bed hospital. Apply to Municipal Hospital, Magrath, Alta.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Graduate, Registered Nurse for **Floor Duty.** Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Staff Nurses (Registered). Initial salary: $76.20 bi-weekly. Increment at the end of 1st and 2nd years of service. 3 weeks' annual vacation. 6-day (48-hour) week. Sick leave — 1 day per month — accumulative. Pension Plan. Excellent living accommodation. Apply to Supt. of Nurses, Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont.

SURGICAL NURSE WANTED

An experienced Surgical Nurse is required for a permanent position at the **Hospital for Mental Diseases, Selkirk, Manitoba.**

Salary schedule: $140 to $165 a month, less $25 a month for full maintenance (board and room, uniforms and laundry). Full Civil Service benefits — three weeks' vacation with pay annually, liberal sick leave with pay, Superannuation Fund privileges, etc. Apply at once to:

MANITOBA CIVIL SERVICE COMMISSION
247 Legislative Building, Winnipeg

or to your nearest National Employment Service office

Assistant Superintendent. Salary: $125 per month and maintenance. 8-hour duty and 6-day week. Apply, stating age and experience, to Miss C. MacCullie, Supt., County of Bruce General Hospital, Walkerton, Ont.

Science Instructor for 155-bed hospital. Yearly salary: $1,920. 44-hour week. 1 month's vacation with pay. Apply, stating qualifications, experience, when services available, to Director of Nursing, Holy Family Hospital, Prince Albert, Sask.

Director of Dietetics. Hospital offers post-graduate course for Dietitians. Duties commence May 1, 1948. Apply, stating training, experience, salary expected, and giving references in first letter, to Medical Supt., University of Alberta Hospital, Edmonton, Alta.

General Duty Nurses. Salary: $110 per month starting pay with time bonuses. 3 weeks' vacation with pay. 8-hour day and 6-day week. $10.00 extra living-out allowance. 2 weeks' sick leave per annum. Full maintenance. Ideal living conditions. Fine nurses' residence. Amount and terms of time bonuses to be decided by Board. Apply to Supt., Alexandra Marine & General Hospital, Goderich, Ont.

Registered Nurse for Community Hospital where excellent salaries are paid. Living accommodation provided. For particulars write to Dr. H. R. Clouston, Supt., County Hospital, Huntingdon, P.Q.

Director of Nurses for 400-bed General Hospital with Training School of approx. 175 student nurses. Apply, stating date of graduation, qualifications, experience, etc., and when services would be available, to Office of Medical Supt., Royal Jubilee Hospital, Victoria, B.C.

Nursing Arts and Science Instructors for 110-bed hospital with accredited Training School. Salaries open. Full maintenance. 8-hour day. 1 month's annual vacation with pay. Duties to begin immediately. Apply to Director, Children's Hospital, Halifax, N.S.

Registered Nurse for Ward Supervision. Also Nurses for General Duty. 100-bed General Hospital in Western Ontario. 8-hour day and 6-day week. Apply, stating qualifications, experience, salary expected, and date available, to Administrator, General Hospital, Woodstock, Ont.

Directress of Recreation to develop program with women and girls in St. Thomas, Ont. Full-time work. Not required to assist with physical training program. Applicants should have ability to meet public easily. Age limit: 35 years. Salary range: $1,600-$1,800 per year. Apply to Mr. E. C. Drollard, Director of Recreation, City Hall, St. Thomas, Ont.

Public Health Nurse (qualified). Apply, stating qualifications, age, experience, and salary expected, to C. A. Warren, M.O.H., Township of York, Keele St. & Elora Rd., Toronto 9, Ont.

Improvised Home Nursing Equipment

THE November, 1947, issue of the *American Journal of Nursing* carried a description of some novel improvised equipment which had been developed as a term project at the Vanderbilt University School of Nursing. None of the pieces was expensive and all might be constructed with comparative ease in the home.

The following directions concern some of the devices which will assist any nurse to increase her patient's comfort and facilitate nursing care in the home:

USE LAVORIS
As a Mouthwash
In the sick room
It coagulates and clears away offensive matter

The Shampoo Back Rest

The problem was to create a device which would add to the patient's comfort during a shampoo in bed. It was constructed in the following manner:

1. A piece of plywood 24½ inches by 20 inches was used as the base.

2. Another piece 24 inches by 18½ inches was attached to the baseboard at one end, secured with metal braces, and slanted at a 60° angle to serve as a back rest. A half-moon was cut from the centre top of this board to provide support for the neck during the shampoo.

3. A third piece of plywood, cut 22 inches wide and shaped by sawing, was used as a funnel-shaped drainboard. Small strips of wood were attached to form the sides.

4. The drainboard was attached to the back rest at the base of the half-moon. The drainboard was slanted at a 45° angle and supported by two pieces of wood 10 inches high and 1 inch square.

5. The back rest was padded with newspapers and covered with oilcloth.

6. A baby's bathtub was placed on the baseboard to receive water from the drainboard.

The total cost of this piece of equipment was $1.51.

Bedside Table

This bedside table included a magazine rack, towel rack, and serving tray. Materials used were two orange crates, two apple crates, a few additional short strips of wood, nails, and white paint.

The details of construction are as follows:

1. The ends of the orange crates were used in two thicknesses for the bottom of the table, which was 22¾ inches by 11¾ inches.

2. Bottoms and sides of the orange crates, 26 inches high, were used as the sides and back of the table.

3. Partitions of the orange crates were used for the middle shelf.

4. The table was elevated on 4-inch legs.

5. The serving tray was made from the sides of the apple crates. Eight-inch legs were fitted into the inside corners of the table and fastened with nails. Strips of wood were used to brace the legs.

6. Four narrow strips of wood were nailed near the edge of the tray to keep the dishes from sliding off.

7. A magazine rack was devised by nailing three slats from the bottom of an apple crate to strips of wood at each end, then bracing them against the table at one end.

8. To provide a towel rack, the ends of a piece of broom handle were nailed to 2-inch by 1½-inch blocks, which in turn were nailed to one side of the table.

9. Curtains for the front of the table were made from flour sacks.

10. The total cost of the table was 81 cents.

Many folks learned "Now I Lay Me Down to Sleep—" at their mother's knee. Many still lisp it as they fall asleep. But few give thought to the needs and dangers of the day. Recently the president of a service club gave a parody on it which might be good for us to say each morning:

Now I get me up to work
I pray the Lord I shall not shirk,
And if I die before tonight,
I pray the Lord my work's all right.

The Arkansas Banker